NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Nebraska Department of Health and Human Services
AFFIDAVIT FOR OUTPATIENTS MEDICATION REQUEST FORM
(MH004) MH004

Financial Responsibility
P.O. Box 94949
Lincoln, NE 68509

STATE OF NEBRASKA: COUNTY OF _____) SS.

The undersigned, being first duly sworn deposes and says that:

The patient's name is _____, and patient is _____years of age, and resides at _____; and

The patient has been discharged from Mental Health Board ordered treatment from the facility identified as _____; and

(a) The patient qualifies as a person who is unable to pay under the same standards of ability to pay set forth in Neb.Rev. Stat., §§ 83-363 to 83-380, and will submit information to the Financial Responsibility Division of the Department of Health and Human Services upon its request, to substantiate that fact;
(b) That prescription medication has been prescribed as necessary for the patient's mental health treatment; and

(c) That the patient's treating physician is

Dr._____

whose address is_____

_____
(Signature of Patient or Guardian)

_____
Typed name of Affiant

Subscribed in my presence and sworn to before me this _____ day of _____, _____.

Notary Seal

_____
Notary Public

OFFICE USE ONLY

DHHS/Financial Responsibility _____ Date ___ /___ / ___
Signature

Center Pharmacist_____ Date ___ /___ / ___
Signature

White – Financial Responsibility Division Yellow – Pharmacist Pink – Patient's Record

INSTRUCTIONS FOR FORM MH004

1. Patient or guardian will fill out the Affidavit (Form MH004) and give the form to the facility or treating physician.

2. Facility physician or treating physician will complete the Medication Request Form for Outpatients (Form MH005). The pink copy of each form will be kept in the patient's medical record.

3. If a DHHS "Financial Questionnaire used for determining ability to pay" is not on file with the Financial
Responsibility Division, patient or guardian will also fill this out and send to the Financial Responsibility Division at the address listed on the top right corner of form MH004.

4. White and yellow copies of both the form (MH004 and MH005) and Financial Questionnaire, if needed, shall be mailed to the Financial Responsibility Division at the address listed on the top right of each form or a Regional Center pharmacy.

5. Prescribed medication, along with the yellow copy of form MH005, will be sent to the patient's specified treating physician by a Regional Center pharmacy.