Ministry of Health

Form 22
Mental Health Act

Financial Statement
Section 55 of the Act

☐ Urgent Financial Matter

Please PRINT clearly.

1. Name of Patient in Full *(Last Name, First Name)*: ______________________

2. Gender: ______________________

3. Name of Psychiatric Facility: ______________________

4. Home Address: ______________________

   ____

5. Date of Birth and Place of Birth: ______________________

6. Occupation: ______________________

7. Name of Employer: ______________________

8. Address of Employer: ______________________

   ____

9. Name, address, and telephone number of patient's spouse or partner, *if any:*

   Name *(Last Name, First Name)*: ______________________

   Address: ______________________

   ____

   Telephone Number: ______________________

10. Give the names and ages of any dependants whom the patient has to support:

	Names (Last Name, First Name)	Age
i.		
ii.		
iii.		

11. Give patient's

    a. Social Insurance Number *(if known)*: ______________________

    b. Health Card Number: ______________________

    c. If other medical insurance plan, state name of company and contract number:

    ____

    ____

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Real Estate

12. Real Estate owned or co-owned by the patient:

    a. Address(es): ____________________

    ____

    b. if occupied, relationship of occupant: ____________________

13. If property of the patient has been rented, give the following information:

    a. Name of tenant: ____________________

    b. Address of the tenant if different from the above: ____________________

    ____

    c. To whom has the rent been paid? ____________________

14. Patient's current income and sources of income *(if known (e.g. ODSP, CP, ODB, pensions, etc.)*:

Source of Income	Amount	Source of Income	Amount

15. Patient's bank account(s) *(if known)*:

    a. Branch: ____________________

    b. Bank Acoount Number: ____________________

    c. Joint or solely owned: ____________________

16. Money owing to patient *(if known)*: ____________________

    ____

17. Patient's known debts *(e.g. mortgages, credit card, line of credit)*: ____________________

    ____

18. Any other assets known to be owned by the patient *(cars, snowmobiles, etc.)*:

    ____

    ____

    ____

    ____

    ____

    ____

    ____

19. Does the patient have a will? ☐ No ☐ Yes *(specify location of the will)* ______________________

Name of Lawyer who assisted *(if known)*: ______________________

20. Does the patient have a power of attorney for property? ☐ Yes ☐ No

Copy attached? ☐ Yes ☐ No

Contact information for attorney *(if known)*:

____

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21. Any other information relevant to the administration of the patient's financial affairs including urgent financial information that requires immediate attention.

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______________________	______________________
(Signature of the person completing the form)	(print name of the person completing the form)
______________________	______________________
(address)	(relationship to patient)

Date ______________________
(day / month / year)

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