DEPARTMENT OF HEALTH

# 2026 Mental Health Safety Net Grant

# Qualifying Data Attestation

Organization Name: _____

Number of Uninsured Patients (not encounters) Under Age 21 Receiving Mental Health Services between July 1, 2024 and June 30, 2025: _____

Source of Data (how did you determine this number): _____

Name of Person Providing Qualifying Data: _____

Title of Person Providing Qualifying Data: _____

By signing this form, I certify that the number of uninsured patients under age 21 receiving mental health services between July 1, 2024 and June 30, 2025 is true and correct.

Signature: _____

Date: _____