MENTAL HEALTH FUND
PATIENT/CLIENT APPLICATION

Requests for financial assistance of up to $5,000 may be made from a licensed behavioral health practitioner or organization/agency; and must include this form and a letter describing the applicant's circumstances and financial need. Please fax to ACF at 970.920.2892 or email to directassistance@aspencommunityfoundation.org.

DATE: ________________

REFERRAL INFORMATION

PROVIDER NAME: ____ CREDENTIAL: __________________________________

PHONE: ___________________________________ EMAIL: ____

PATIENT/CLIENT INFORMATION

NAME: ____ AGE: ____________________________

STREET ADDRESS: ____ CITY: _______________________ COUNTY ________________

NUMBER OF PEOPLE IN HOUSEHOLD: ____________________________ AGE(S): ____

OCCUPATION: ____

ESTIMATED MONTHLY INCOME: ____ ESTIMATED MONTHLY EXPENSE: ______________________

HEALTH INSURANCE: ☐ Private - Insurance Company:____Plan:_______________________

☐ Medicaid ☐ Medicare ☐ Uninsured

PLEASE DESCRIBE FINANCIAL NEED OF CLIENT: ____

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Please describe why the patient's needs cannot be met by our community mental health center, mind springs health which accepts Medicaid/Medicare and most private insurance and which offers a sliding fee scale for patients not eligible for health insurance:

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I give my permission to send a request to ACF. I understand that my clinical information will be shared with ACF and the Fund advisors. (Required)

Patient Signature: ____ Date: ____

REQUEST FOR SERVICES

ASSISTANCE REQUESTED FOR: ☐Therapy ☐Psychiatric Assessment ☐Medication Management

CLINICAL JUSTIFICATION (please attach a second document to provide this information if needed)________________________________

CURRENT PROBLEM/SITUATION: ____

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GOALS FOR TREATMENT: ____

TREATMENT PLAN (including use of ancillary services): ____

OUTCOME PREDICTABILITY: ____

NUMBER OF SESSIONS REQUESTED: ____________________________OVER WHAT TIME PERIOD: ______________________________

AMOUNT PATIENT IS ABLE TO PAY PER VISIT:$_____________ TOTAL SUBSIDY REQUESTED: $____________

FOR ACF USE ONLY ☐ APPROVED $_________________ ☐ DENIED

AUTHORIZED BY: ____ DATE: ________________________________