MENTAL HEALTH FUND

Patient Application

Date:_____

Provider Name: _____ Credential(s): _____

Provider Phone: _____ Email:_____

Patient name: _____ Age: _____

Mailing Address:_____

County of Residence: _____ Occupation:_____

Estimated monthly income: _____ Estimated monthly expense total: _____

Health insurance:

- ☐ Private - insurance company: _____ Plan: _____
- ☐ Medicaid
- ☐ Medicare
- ☐ Uninsured

Please describe financial need of client: _____

_____

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 insurances and offers a sliding scale for patients not eligible for health insurance. _____

_____

_____

I give my permission to send a request to Aspen Strong. I understand that my clinical information will be shared with Aspen Strong advisors. (Required)

Signature: _____ Date: _____

Request for Services

Assistance requested for (circle one): Therapy Psychiatric Assessment Medication Management

Clinical Justification (Please attach a second document to provide this information if needed): _____

Current problem/situation: _____

Goals for treatment: _____

Treatment plan (including use of ancillary services):_____

Outcome predictability**:** _____

Number of sessions required: _____ Over what time period:_____

Amount patient is able to pay per visit: $_____ Total subsidy requested: $_____

For ASF use only: □ APPROVED $_____ for _____ # of sessions or □ DENIED

Signature: _____ Date:_____

HIPAA AUTHORIZATION FORM

I, _____, hereby authorize the use or disclosure of my protected health information as described below:

My provider, _____, is authorized to disclose the following protected health information to Aspen Strong.

The health information that may be disclosed is mental health-related.

The purpose of this use or disclosure is to seek funding through Aspen Strong.

The authorization form is valid beginning on the date that it is submitted and it expires exactly one year from the date of signing.

I understand that the information used or disclosed under this authorization may be subject to re-disclosure by the persons or organization receiving it and may no longer be protected by federal privacy regulations. I have the right to refuse to sign this form. I also have the right to revoke this authorization once signed, in writing, at any time. I understand that any action already taken in reliance on this authorization cannot be reversed and revocation will not affect those actions.

By: _____ Date: _____