aspen COMMUNITY foundation
BE THE DIFFERENCE

Mental Health Fund
Patient/Client Application DATE: ______________________

*Requests must include this form and a letter describing the applicant's circumstances and financial need. Please fax the form and letter to **ACF at 920-2892**.*

Referral Information
Provider Name: ____________________ Credential: ____________________

Provider Phone: ____________________ Email: ____________________

Patient/Client Information
Patient/Client Name: ____________________ Age: ____________________

Mailing Address: ____________________

County of Residence: ____________________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: ____________________

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** $____________________ for ______________# of sessions **or** □ **DENIED**___________

Signature: ____________________ Date: ____________________