Mental Health Fund

Application for Assistance

Please note that all sections of this application must be completed. If any sections are left blank, we will be unable to consider your request for support.

Personal Information

Your Name: ____Date of Birth:__________

Physical Address: ____

Mailing Address: ____

Home Phone: __________________________Work Phone:_____________________________

Cell Phone: ____________________Email Address: ___________________________________

Insurance Information

Circle all that types of coverage you have: Medicaid / Medicare / Employer / Marketplace / Disability / Self-Pay / None / Other

Name of Insurer: ______________________________Deductible Amount: $_______________

Physician(s): ____

If you do not currently have insurance, have you applied for Medicaid / Marketplace / COBRA?

Would you like assistance applying for coverage? YES / NO

Other Personal Data

Marital Status: Married / Single / Divorced / Living with Partner / Shared Household / Other

Years at current address: __________ Rent/Own Is Wyoming your permanent residence? Y/N

Landlord or Lender Name & Address: ____

Number of dependents:___________ Ages of dependents: _____________________________

Current Employer: _____________________________ Length of Employment: ____________

Supervisor: __________________________________ Phone: ____________________________

Request for Support
What is the total amount of your request? $____

Briefly explain the nature of your needs at this time (e.g., preventive care, doctor's visit, screening, medication, equipment, etc.).

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Have you ever received funds from the Mental Health Fund? Yes/No
If yes, what is the total amount of funding received in each year:
2019: $_____________ 2018: $_______________

Have you completed a Patient Assistance application at St. John's Health: YES /NO

Please circle the names of all other agencies or resources you have contacted for assistance:

CES / CLIMB Wyoming / Community Counseling Center / Community Resource Center / Community Safety Network / Curran-Seeley / DFS / DVR / El Puente / Free Clinic / Latino Resource Center / Local Religious Group / Mission / Mountain House / Private Counselor / Public Health / Senior Center / TYFS / Other: ____

Signature of applicant:____Date: ______________

Printed name:

Signature of referring agency staff member:____

Printed name:

Signature of Foundation staff: ________________________________Date: ______________

Please return your completed application to Lindsay Long at St. John's Health, at 307-739-6133 or llong@tetonhospital.org.