Therapy Financial Assistance Application

Keepers of the Flame® Foundation, Inc. Therapy Assistance Program

Client Eligibility:

1. Breast Cancer Patient in Georgia
2. Require Financial Assistance for Therapy Sessions

Application Requirement Check List:

☐ Completed Application below: **Page 1**
☐ Signed Waiver Form: **Page 2**

Keepers of the Flame Admin
session approved: ______________
Date Approved: _________________
Total Cost: ____________________
Approved by: __________________

Email applications to Keepers of the Flame: Vanessa Brink (Director): programs@togetherweweather.org

To Be Completed by Patient

Note to patient: A maximum of 5 sessions can be approved at a time; you may choose less than that, and/or you may also reapply for additional sessions after completion of those that are approved.

Date: ___________________ **Client Name:** ____**Age:** _____________

Client Email: ____

Are you a breast cancer patient?	*Level of Care Requesting:*	
☐ Yes ☐ No	☐ Professional Counseling ☐ Psychiatrist	
Total Number of Sessions Requested	*Annual HH Income:*	*Total number of people in household*
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5	☐ < $35,000 ☐ $35,000-$49,999 ☐ $50,000- $64,999 ☐ $65,000-$79,999 ☐ $80,000-$94,999 ☐ >$95,000 **Total Household Income: ______________**	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 or more
Brief explanation of how this program would benefit you: Ex: Three-year breast cancer survivor experiencing anxiety		

Consent: By signing below, I hereby authorize Keepers of the Flame® Foundation, a not-for-profit corporation, to share any and all information provided in this application to their grant providers and counseling partners, in order to assess eligibility, provide assistance, process invoices on my behalf, and evaluate program effectiveness. I understand that these person(s)/organization(s) may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information provided on this application. I understand that this application includes ALL of the items listed in it, and I consent for Keepers of the Flame® Foundation to use the information provided to act on my behalf. I further understand that the submission of this application does not guarantee assistance. I understand that Keepers of the Flame® Foundation will not review mental healthcare office notes or information shared with mental health professionals, nor will they have access to my medical health records. I also understand that Keepers of the Flame® will not cover any "no-shows" and that I will be subject to the "no-show policy" of the counseling center I choose to schedule with.

Client Signature: ____________________________________ Date: _________________________________

To Be Completed by Counseling Partner

Name of Business: _____________________________________ **Contact Person:** ___________________________________

Are you able to accommodate the number of sessions client is requesting?	☐ Yes ☐ No
Cost of each visit for this client (not to exceed $100) or cost of client's copay/visit	$ ________________________/ visit
Total Cost for this client: *(# additional sessions x cost per visit)*	$ ________________________

Invoice Policy: Counselor Partners to invoice Keepers of the Flame® Foundation (programs@togetherweweather.org) following each completed session. Total number of approved sessions must be used/invoiced, unless otherwise noted by Keepers of the Flame, within 3 months of the approval date or by Dec 18 of the year they were approved, whichever comes first. If not used by that date, client may reapply for coverage. KotF does not cover "no-shows". The client will be subject to the counseling center's no-show policy.

HIPAA Waiver Form

I,____, give my permission for my mental health provider's office to disclose my health records with Keepers of the Flame for the purpose of payment of treatment, and for program quality review.

- Keepers of the Flame **will not** review mental healthcare office notes or information shared with mental health professionals.
- The information gathered will be strictly used for payment purposes, and to evaluate the effectiveness of the program.

Form of Disclosure:
Electronic copy or access via a web-based portal Hard copy

I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

This authorization to share my health information is valid from the date of the signature below until I decide to revoke this authorization. I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to:

KEEPERS OF THE FLAME FOUNDATION INC 329 PURPLE PLUM DR RINCON, GA 31326

I understand that:

In the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data. I understand that I do not need to give any further permission for the information detailed to be shared with Keepers of the Flame. I understand by signing this document, it is not a guarantee of payment.

I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

Signature: __________________________________ Date: __________________________

Print your name: ____