How to Apply for Mental Health Access Assistance: Patient Edition

Shanece Bowman

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Touchstone FOUNDATION | Youth Mental Wellness Partners

What You Need

- About 30 minutes
- Electronic/scanned copies of the items below.
  - You can use a scanning app on your phone, such as Adobe Scan, GeniusScan, or CamScanner
- Your insurance card
- Proof of residency
  - driver's license or state ID, bank statement, utility bill, or other official mail that contains a name, address, and a date.
  - You may black out sensitive information such as account numbers. Please do not submit mail from a commercial vendor such as Amazon, Wal-Mart, etc.
- Proof of income
  - the first two pages of your previous year's tax return (Form 1040).
  - Black out your SSN. If you have never filed a tax return, you will need a copy of your pay stub.

Mental Health Copay Assistance

touchstonefound.org/copay/

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Select Language

Logon - Grant Lifecycle Manager

grantinterface.com/Home/Logon?urlkey=lancasterhealth

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Logon

Email Address*

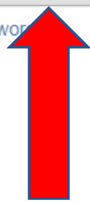
The Email Address* field is required.

Password*

The Password* field is required.

Log On | Create New Account

Forgot your Passwor



Touchstone Foundation

128 East Grant Street Suite 104
Lancaster, PA 17602
717-397-8722

We elevate the mental well-being of youth and children in Lancaster County. We improve access for youth and children's behavioral health through strategic grant-making, mental health copay assistance, and workforce development.

info@touchstonefound.org
www.touchstonefound.org

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https://www.grantinterface.com/User/Register?urlkey=lancasterhealth

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Create New Account - Grant Life
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Cancel Account Creation

Select Language

Create New Account

If you already have an Account, click the 'Cancel Account Creation' button to go to the Logon page

⚠ Using the browser's back button will delete your registration information.

ⓘ This registration process has multiple steps you must complete before you can apply.

Fields with an asterisk (*) are required.

Organization Information

Name*

EIN / Tax Identification Number*

If you are applying for a scholarship and are not applying on behalf of an organization, please type in "NA".

NA

Put NA here; don't enter your SSN

Phone Number*

Address 1*

Address 2

City*

State (i.e. PA)*

Postal Code*

Next >

User Information

Password

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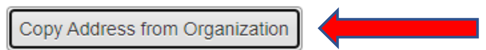
Cancel Account Creation

Organization Information

User Information



Salutation (Mr., Mrs., Dr., etc.)*

First Name*

Middle Name

Last Name*

Suffix

Business Title

Email / Username*

Email / Username Confirmation*

Telephone Number xxx-xxx-xxxx ext. xx*

Mobile Number xxx-xxx-xxxx

Address 1*

128 E GRANT ST, STE 104

Address 2

City*

LANCASTER

State (i.e. PA)*

PA

Postal Code*

17602

Previous | Next

Password

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Cancel Account Creation

Select Language ▼

Create New Account

If you already have an Account, click the 'Cancel Account Creation' button to go to the Logon page

Using the browser's back button will delete your registration information.

This registration process has multiple steps you must complete before you can apply.

Fields with an asterisk (*) are required.

Organization Information

User Information

Password

Your password must be at least 6 characters and is case sensitive.

Password*

Confirm Password*

Previous

Create Account

Type here to search
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Email Confirmation

You will be receiving emails from this system about your request.

To ensure you receive emails from this system we have sent you an email to confirm your account was created successfully. If you do not see an email from *Touchstone Foundation <administrator@grantinterface.com>*, look in your junk or spam folder.

To remove *Touchstone Foundation <administrator@grantinterface.com>* from your spam filter, use the link below.

Click Here for a tutorial about removing email addresses from spam filters.

- I have received the email
- Continue without checking
- I have not received the email

Send Email Again

Continue

Check your email to confirm it is correct!
Then click the continue button

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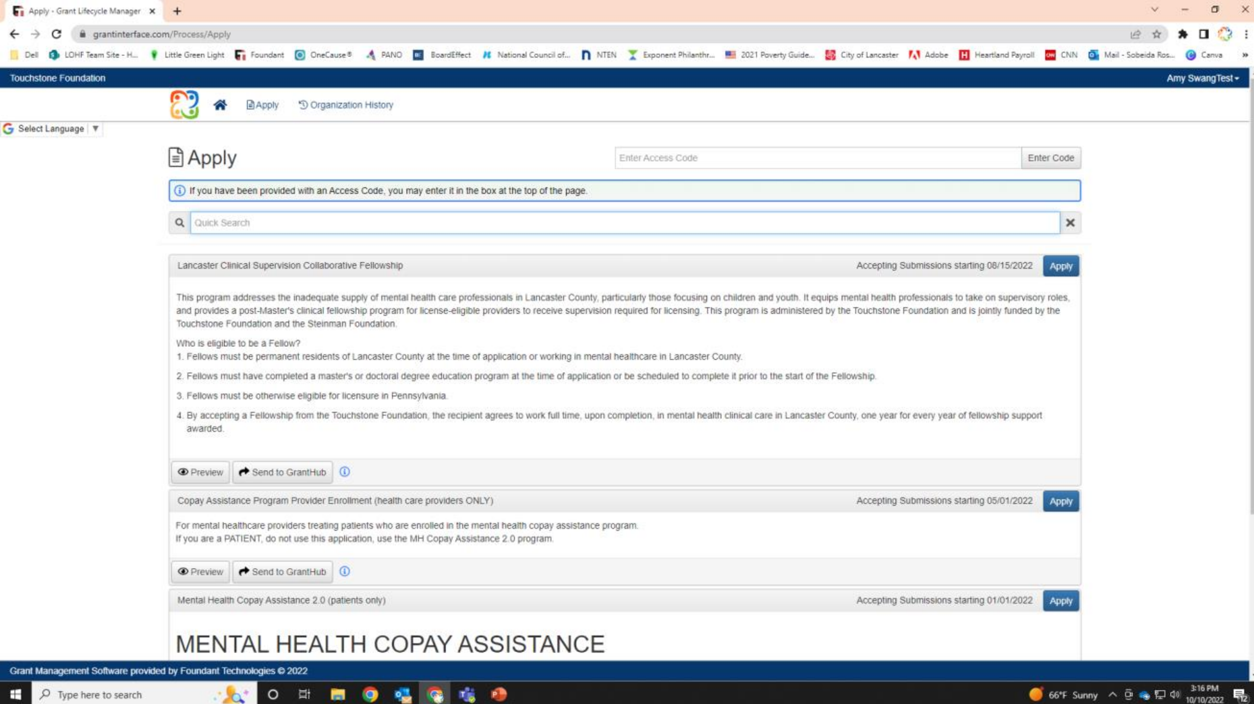
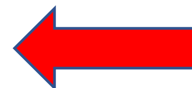
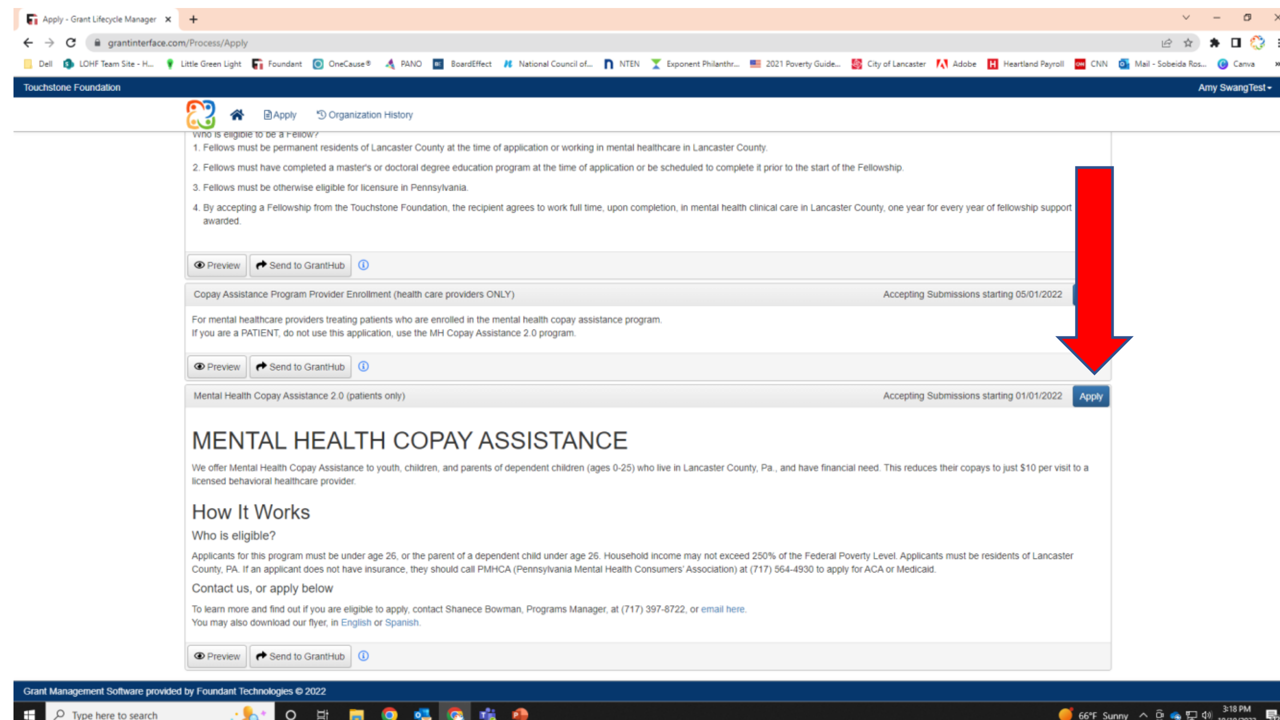




You'll see a screen similar to this.

Scroll down to MENTAL HEALTH ACCESS ASSISTANCE and click the Apply button



No need to click a box here, just review the information and scroll down.

Application - Grant Lifecycle Man

grantinterface.com/Request/Submission/Application?request=8493364

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Current Status: None

STAGE	STATUS	INITIAL SUBMISSION	LAST MODIFIED

Application

Question List

Fields with an asterisk (*) are required.

Mental Health Copay Assistance Program information

Mental Health Copay Assistance Program - Application

Mental Health Copay Assistance Program
128 E. Grant St., Ste. 104 Lancaster, PA 17602

Phone: 717-397-8722

ENROLLMENT APPLICATION

We offer Mental Health Copay Assistance to youth, children, and parents of dependent children (ages 0-25) who live in Lancaster County, Pa., and have financial need. This reduces their copays to just $10 per visit to a licensed mental healthcare provider.

PLEASE NOTE: THE MENTAL HEALTH COPAY ASSISTANCE PROGRAM DOES NOT COVER DEDUCTIBLES

Applicants for this program must be:
-Residents of Lancaster County, Pennsylvania
- Commercially Insured
- Are being seen by a provider who accepts their insurance.
-Under age 26 OR the parent/caregiver of a dependent child
-Total household income may not exceed 250% of the Federal Poverty Level

☐ I'm applying for my child, teen, or young adult
☐ I'm applying for myself as a parent/caregiver of a dependent child, teen, or young adult

Patient Background Information

Applicant First Name*

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This section can be a little confusing. If you are a parent/caregiver, make sure you put the *patient's* last name here if it is different from yours. If you are the patient, put your own last name.

Patient Background Information

Applicant First Name*

Gorgeous

Project Name*

Please enter the last name of the *patient* who will be receiving mental health care.

McAwesomepants

Applicant Status*

- ○ I am applying for my child
- ● I am applying for myself as a young adult less than 26 years old
- ○ I am applying for myself as the parent/caregiver of a child

Child's First Name*

If you are applying for your child, please enter the child's first name. If you are applying for yourself, write 'NA.'

NA

Child's Last Name*

If you are applying for your child, please enter the child's last name. If you are applying for yourself, write 'NA.'

NA

Relationship*

If you are applying for a child, or for yourself as the caregiver of a child, describe your relationship to the child.

Grandparent

Date of Birth*

Date of birth of the person who will be seeing the mental health care provider.

01/01/2000

Financial Eligibility Information

Annual Household Gross Income*

What is the total combined annual income for your household, before taxes? Include salary, wages, tips, child support, alimony/palimony, social security, disability, unemployment, worker's compensation, pension/retirement, interest income, etc. for all of the people living in your household. A good way to find this information is to look at the line "Total Income" on last year's tax return.

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Last year's tax return is your starting point, but if there is a significant change in income or something that impacts your income that isn't reflected on your taxes, you can tell us here.

Financial Eligibility Information

Annual Household Gross Income*

What is the total combined annual income for your household, before taxes? Include salary, wages, tips, child support, alimony/palimony, social security, disability, unemployment, worker's compensation, pension/retirement, interest income, etc. for all of the people living in your household. A good way to find this information is to look at the line "Total Income" on last year's tax return.

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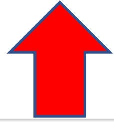


Household Size*

How many people live in your household, including adults, children, and adult dependents?

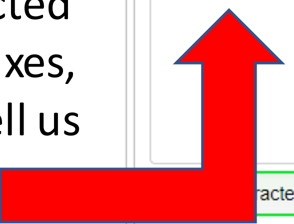
#

Are you claimed as a dependent on your parent's income?*

- Yes
- No

Income Adjustments

Is there anything we should know about your financial status? For example, has your financial status changed significantly since you last filed your taxes? Are you required to pay alimony/palimony or child support for people outside of your immediate household? Do you provided financial support to other people outside of your household, such as grandparents or siblings? If so, you will need to provide proof of these payments in the Supporting Documents section.



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If you are unsure whether you are eligible for this program, you may use this website to determine the Federal Poverty Guidelines for your household size. Multiply your total annual income (gross, before taxes) by 2.5 to calculate our eligibility cutoff of 250% of the federal poverty level.
https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines

Use this website to see if you qualify financially. Don't forget to multiply by 2.5!

https://aspe.hhs.gov/index.php/topics/poverty-economic-mobility/poverty-guidelines

Program Enrollment Information

Insurance*

Write the name of your current health insurance company and plan.

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Insurance*

Write the name of your current health insurance company and plan.

What is your insurance copay amount for mental health care/specialty visits?*

If you do not know this amount, try checking the details on the back of your health insurance card.

$

Deductible*

How much is your deductible? If you don't have a deductible, put 0. THIS PROGRAM DOES NOT COVER DEDUCTIBLES!

$

Deductible for 'specialty' appointments

Primary Care Provider*

Where do you currently get your ***primary*** health care? Please list the name of the doctor's office and/or the name of your doctor where you go for regular health care visits.

Status of Mental Health Care*

Please select one option from the drop-down list below.

Mental Health Care Provider*

Where will you be going for your mental health appointments? Enter the full name and address of the practice. If you know your provider's name, enter that as well. If you are waitlisted at multiple offices, please write down all of them.

I don't know yet

10,000 characters left of 10,000

If you haven't found a mental health care provider yet, here are some great resources.

https://www.psychologytoday.com/us/therapists

If you are having difficulty finding a therapist who accepts your insurance, here are some resources you may find helpful:

https://www.psychologytoday.com/us/therapists

https://www.pa211.org/get-help/mental-health/

https://www.pa211.org/get-help/mental-health/

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Totally optional questions that help us manage and advertise our program. Answer all, some, or none- we appreciate any answers you choose to provide.

Additional Information- Optional Survey Questions

These responses are optional and do not affect your eligibility determination for our program. Your responses can help us improve our program.

How did you hear about our program?

Patient's Age

How old is the person who will be receiving care?

Patient's Race/Ethnicity

Recognizing that these are broad and imperfect groupings, which race/ethnicity would you most consider yourself? Check all that apply. Optional

- ☐ White
- ☐ Black/African/African-American
- ☐ Hispanic/Latinx
- ☐ Native American/Alaska Native
- ☐ Middle Eastern
- ☐ Asian/Pacific Islander
- ☐ South Asian
- ☐ Southeast Asian
- ☐ I belong to more than one of these groups

Patient's Residency Status

Please describe the patient's residency experience in the United States. We are not concerned with legal immigration status. Optional

Language

What language(s) do you speak at home? Optional

Gender

Which option best describes your gender? Optional.

- ☐ Male
- ☐ Female
- ☐ Non-Binary
- ☐ Prefer not to answer

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This is where that scanning app will come in handy. Use a scanner, or a scanning app on your phone/tablet (such as Adobe Scan, Genius Scan, or CamScanner) to create files that you can upload. If you have trouble uploading, please contact us- we are here to help you. Do not get stuck here, we will help you!

Supporting Documents - Upload

Proof of Identification Upload*

Upload a copy of the *front and back* of the health insurance card for the person who will be getting care. THIS PROGRAM DOES NOT COVER DEDUCTIBLES.

Upload a file [4 MiB allowed]

Proof of Residency Upload*

Upload an official dated document that lists your name and address in Lancaster County. Examples include drivers license or state ID, bank statement, utility bill, or other official mail that contains *name, address, and a date*. You may black out sensitive information such as account numbers.
Please do not submit mail from a commercial vendor, such as Amazon, Wal-Mart, etc.

Upload a file [5 MiB allowed]

Proof of Income - Upload*

Upload a copy of the first two pages of your previous years tax return (Form 1040).
If you have never filed a tax return, upload a copy of your pay stub.

Upload a file [5 MiB allowed]

Additional Proof of Income

If your income has decreased since your last tax return, upload a copy of your most recent pay stub, and/or other proof of current income. Examples include unemployment, social security, worker's compensation, disability, pension/retirement, self-employment quarterly income/expenses statement, etc. You may combine multiple documents into a single upload.

Upload a file [5 MiB allowed]

Additional Proof of Income

If your income has decreased since your last tax return, upload a copy of your most recent pay stub and/or other proof of current income. Examples include unemployment, social security, worker's compensation, disability, pension/retirement, self-employment quarterly income/expenses statement, etc. You may combine multiple documents into a single upload.

Upload a file [5 MiB allowed]

Pay Stub Information

If you have uploaded a pay stub, specify the date you were first employed, and how often you are paid (weekly, bi-weekly, monthly) for each job.

Additional Information

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Apply | Organization History

This is what allows your provider to send us bills on your behalf.

Additional Information

Is there any additional information you would like to provide that may clarify your eligibility for our program? Please do not enter medical information that is protected by HIPPA.

10,000 characters left of 10,000

HIPPA Authorization

Please Type Your Full Legal Name*

I hereby authorize Touchstone Foundation at 128 E. Grant Street, Lancaster, PA 17602, to receive and use protected health information for the above-named patient once enrolled in the Mental Health Copay Assistance Program. The Foundation may receive and use information regarding the following: **patient's name, parent/guardian name (if applicable), date of birth, name of mental health care provider, date, time, and location of treatment, and billing information**. The intended use of this information is to provide financial assistance for provider-billed copays. I understand that I may revoke this authorization at any time by notifying Touchstone in writing of my desire to revoke. However, I understand that any action already taken in reliance on this authorization cannot be reversed and my revocation will not affect those actions.

Gorgeous McAwesomepants

Submit

Please Type Your Full Legal Name*

I certify that the above information is a full and complete disclosure of my income and address. I certify that the above information is true to the best of my knowledge and there is no attempt to commit fraud. I understand that appropriate action will be taken if the above information is found to be false.

Gorgeous McAwesomepants

Please Type Today's Date*

I certify that the above information is a full and complete disclosure of my income and address. I certify that the above information is true to the best of my knowledge and there is no attempt to commit fraud. I understand that appropriate action will be taken if the above information is found to be false.

10/12/2022

Abandon Request | Save Application | Submit Application

If you get an error message for your uploaded documents when you submit, try clicking the 'Save Application' button first, then click Submit.

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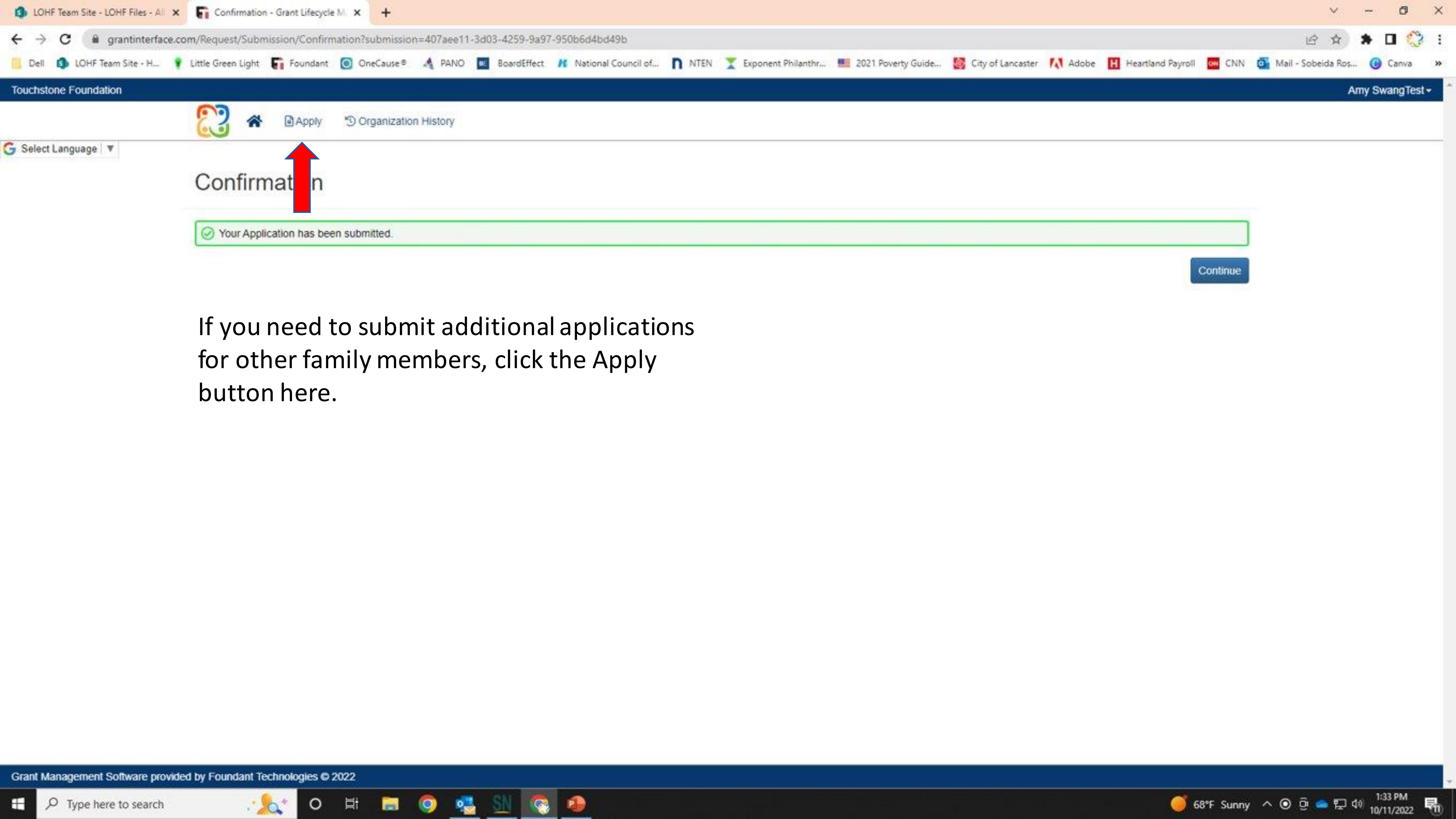

If you need to submit additional applications for other family members, click the Apply button here.

What Happens Next?

- You should get a response within about five business days. If you don’t, please contact us.
- If you are approved, you will get a letter in the mail with an enrollment card. You will present that card to your provider at your appointments.
- Your provider will also receive a letter notifying them that you are enrolled in our program.
- You will need to submit a new application in one year to confirm you are still eligible.