



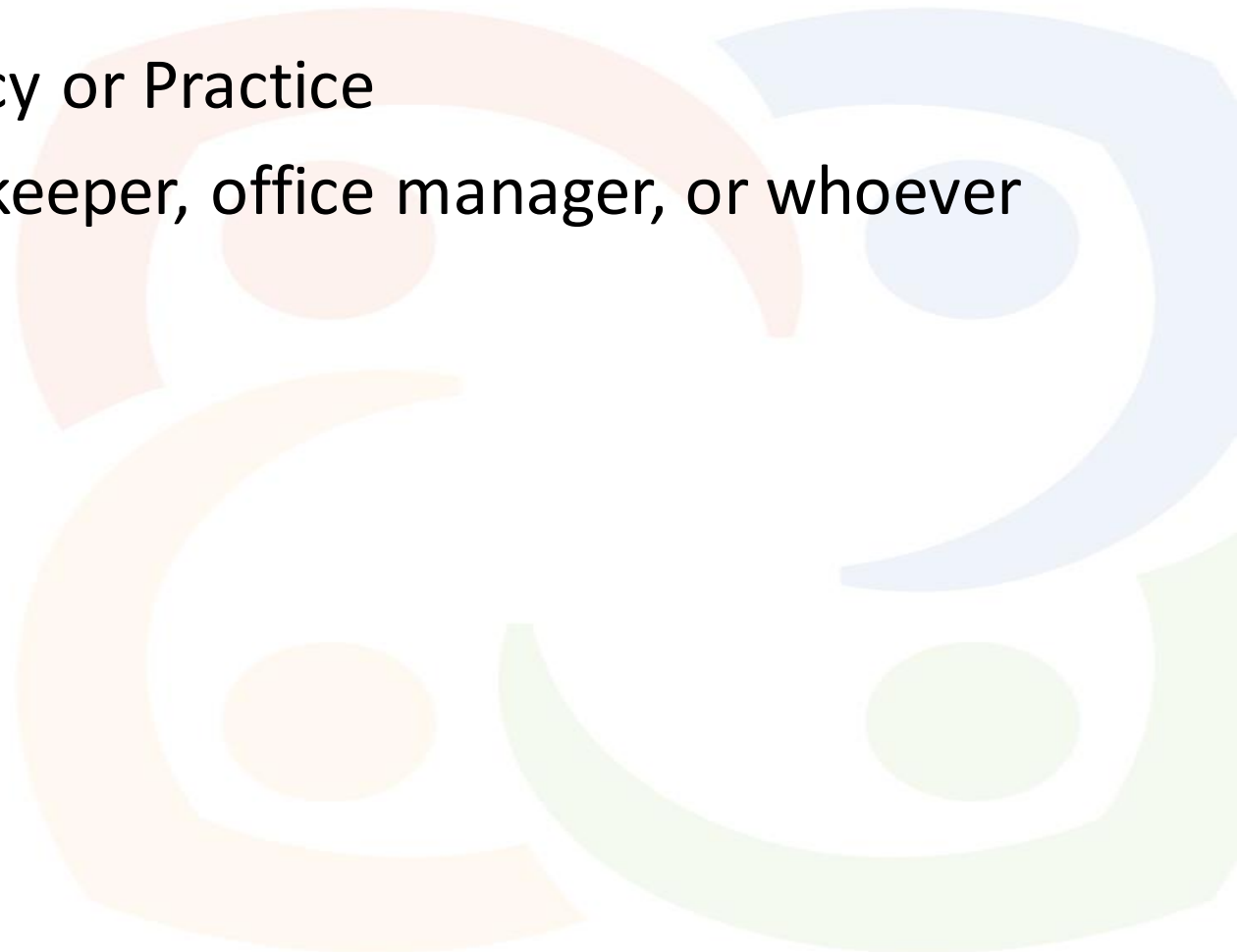
How to Apply for Mental Health Access Assistance: Provider Edition

Shanece Bowman

717-397-8722

What You Need

- About 15 minutes
- Contact information for your Agency or Practice
- Contact information for your bookkeeper, office manager, or whoever handles billing/invoicing



MENTAL HEALTH COPAY ASSISTANCE

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 behavioral healthcare provider.

Click Here

Apply Now ▶



Select Language ▾



Logon

Email Address*

The Email Address* field is required.

Password*

The Password* field is required.

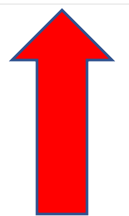
[Log On](#) [Create New Account](#)

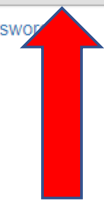
[Forgot your Password](#)

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


This site is compatible with Google Translate



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.

ℹ 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*
<input type="text"/>	<input type="text" value="NA"/> Put NA here; don't enter your SSN/EIN
Phone Number*	Address 1*
<input type="text"/>	<input type="text"/>
Address 2	City*
<input type="text"/>	<input type="text"/>
State (i.e. PA)*	Postal Code*
<input type="text"/>	<input type="text"/>

Next >


User Information

Password

Cancel Account Creation

Organization Information

User Information

Copy Address from Organization 

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* Address 2

City* State (i.e. PA)*

Postal Code*

< Previous

Next >

Password

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Organization Information

User Information

Password

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

Password* **Confirm Password***

← Previous

Create Account

Email Confirmation

i 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.

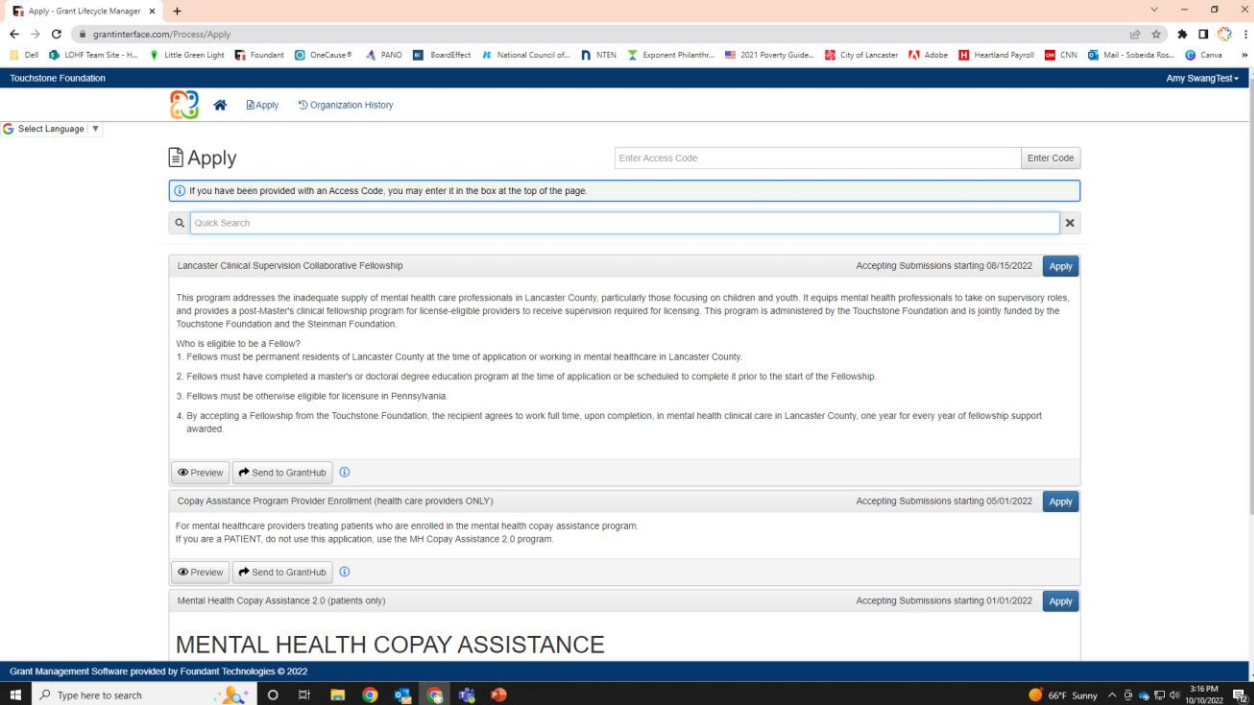
[Click Here](#) for a tutorial about removing email addresses from spam filters.

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

Send Email Again

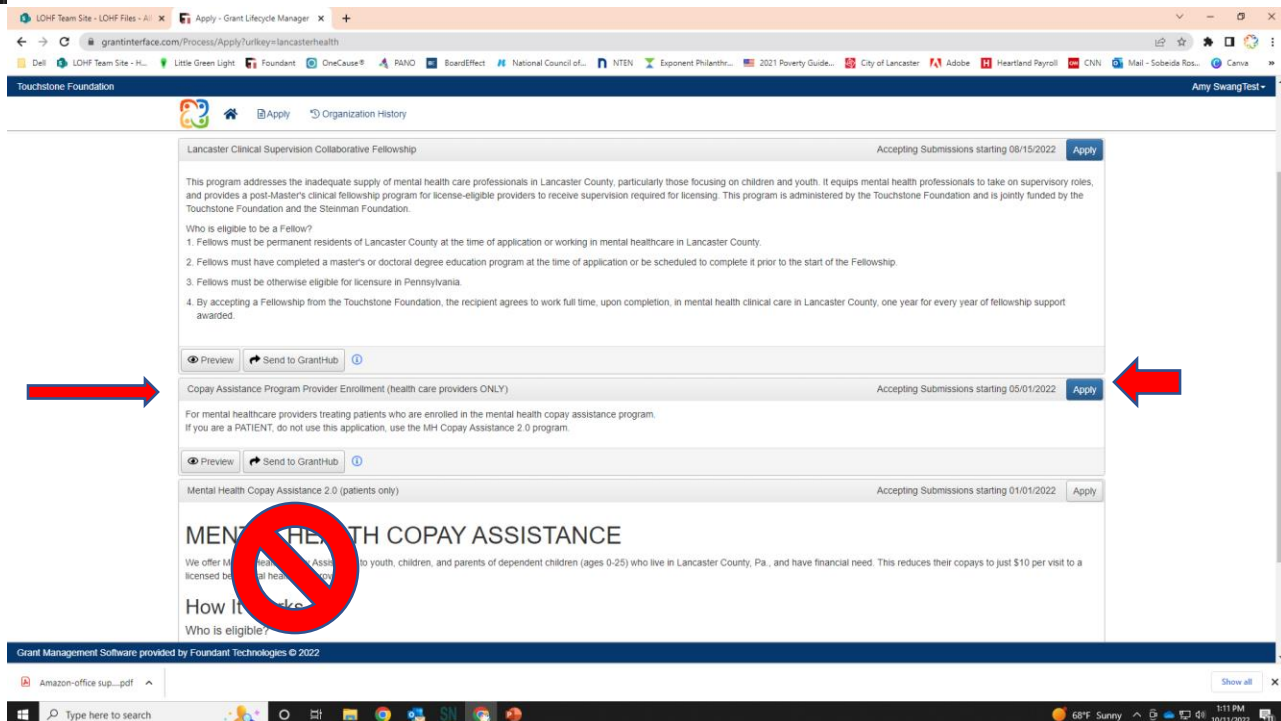
Continue

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



You'll see a screen similar to this.

Scroll down to MH Access Assistance Program Provider Enrollment (health care providers ONLY) and click the Apply button



Current Status: None

STAGE	STATUS	INITIAL SUBMISSION	LAST MODIFIED
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Application

Question List

Fields with an asterisk (*) are required.

Contact Information

Healthcare Practice Name*

Who should we make checks out to? The legal name of your healthcare practice as used on business documents. If your practice is a sole proprietorship, and doesn't have a separate business name, this might be your own name.

Primary Point of Contact*

Who should we contact with billing/payment questions? This will be a bookkeeper or office manager if you have one.

Primary Email*

What email should we use for the primary point of contact?

Primary Phone*

What phone number should we call to reach the primary point of contact?

Mailing Address*

The address where you would like us to mail payments

Secondary Contact Information

Please enter any additional contact information here.

Enter your information here.

Review our program information

> Contact Information

Program Information

In order to be eligible for our program, patients must be:

- Residents of Lancaster County
- Under 26 years old OR the parent/caregiver of a person under 26
- Total household income cannot exceed 250% of the federal poverty level
- Have commercial insurance
- Patients must re-enroll with us annually so we can verify that they are still eligible. We provide patients with an enrollment card that shows their expiration date- please check this date with your patients before billing us.
- To view the patient application, go to Mental Health Access Assistance 2.0 (patients only).

- Please do NOT send us the patient's diagnosis, ICD codes, or other Protected Health Information
- Patients enrolled in or eligible for Medicaid/Medical Assistance are not eligible for our program. We encourage these patients to seek care from a Medicaid-approved health clinic.
- Patients who are undocumented will generally be referred to community health centers. We encourage these patients to contact us directly so we can consider each case individually.
- If you have a patient who would benefit from a specific type of therapy not covered by their insurance, please contact us to discuss an exceptional payment plan.

After the patient has received care:

1. Bill the insurance company as usual
2. Bill Touchstone Foundation for \$40. If the patient's copay/co-insurance is less than \$40, bill us for that amount.

- Your invoice to us must include the amount paid by insurance, the amount charged to the patient, and the amount waived by the practice, if any. We can provide you with an invoice template if you would like one.
- Your invoice to us must use the same first and last name that the patient used to enroll in our program (no nicknames). If your practice uses additional security to mask this information, please contact us so we are able to match your invoicing to our enrollees.
- You must invoice us within 90 days of the visit. If you are experiencing a delay, please contact us directly so we may discuss an exception. Under no circumstances will we be able to reimburse for care from the previous calendar year after April 1st.

If you have any questions about the purpose or administration of our program, please contact us at 717-397-8722. We would love the opportunity to answer any questions you may have so we can provide the greatest benefit to your patients!

Our Non-Discrimination Policy:

Touchstone Foundation provides equal employment opportunities to all employees and applicants for employment consideration with applicable law. All qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity, national origin, disability status, protected veteran status, or any other characteristic protected by law.

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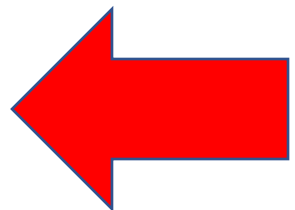
The Community Benefit Organizations and Agencies served by Touchstone Foundation must serve the members of the Lancaster County community without discrimination on the basis of race, color, religion, sex, gender identity, national origin, disability status, protected veteran status, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by Touchstone Foundation.

Additionally, Touchstone Foundation does not generally provide grant support to individuals, for-profit organizations, firms, or companies, athletic, recreational, labor, fraternal, political, lobbying, or social organizational, or national organizations without local affiliation. Touchstone Foundation will only fund programs at religious agencies and organizations, or other organization, if the programs are open to all members of Lancaster County without regard to religious affiliation or belief and contain no bias toward any religion.

Please type your full legal name*

By participating in our program, you agree to abide by our non-discrimination policy

Please type today's date*



Sign our non-discrimination policy and submit. We take this policy very seriously.

What Happens Next?

- We review your application- usually within a few days. If you haven't heard anything after five business days, please contact us.
- Once you are approved, we will send you an enrollment letter with additional information.
- If your primary point of contact, email, phone, or mailing address change, please contact us so we can update your profile.
- Enrolled patients receive a card to present at appointments.
- Once you have seen an enrolled patient, you can start sending us invoices. We will be happy to provide you with an example invoice if you don't already have one to use.

Confirmation

 Your Application has been submitted.

[Continue](#)

All done!