Alex Panton Foundation

Request for Financial Aid Form

The **Alex Panton Foundation** provides Financial Aid to **persons legally resident in the Cayman Islands up to thirty (30) years old, who are seeking or currently receiving care for mental illness(es) and who are uninsured or underinsured**.

Financial Aid is provided on an individual basis and is assessed by the APF Financial Assistance Policy Committee (the Committee) of the Board of Directors within two (2) weeks following the submission of the Request for Financial Aid Form.

All applications are reviewed on a case by case basis. The granting of assistance in all cases is at the sole discretion of the Committee. Failing to disclose any relevant information, providing false information or failing to advise of any change of financial circumstances after assistance has been provided may result in assistance being denied or terminated or withdrawn without further notice.

This form must be completed with the help of your chosen Service Provider. Any follow-up must also be made via the Service Provider.

Disclaimer:

The information submitted in this form is for the sole use of the Provider and the members of the Committee. This information will be used only to make a determination on the amount and term of the financial assistance. The form will be submitted through a designated email address for the purpose of exchange of information between the Committee and the Service Provider. The email address for submission of forms is assistance@alexpantonfoundation.ky

Please answer all questions. If a question is not applicable to you, please answer N/A. If you need additional space to answer any question, please use the space provided on the Additional Information page of this application.

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SECTION A: Patient Information

Name of Applicant: _____

Patient Name (if different from applicant): _____

Relation to Patient: _____

Gender (tick where appropriate): Male: _____ Female: _____Other: _____

D.O.B: _____

Do you have a disability, if yes, please describe?

_____
_____
_____
_____

Mailing Address: P.O. Box _____ Island: _____ Postal Code: _____

Physical Address: House #:_____Street:_____District:_____

Please provide directions to your house:

_____
_____
_____

Do you rent or own your house? _____

Home Phone:_____Work Phone:_____Cell Phone_____

Email Address: _____

Please give the name of your school and years attended (even if you are no longer in school):

_____
_____

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SECTION B: Service Provider Information

Service Provider Name: _____

Service Provider Address: _____

Name of therapist/ assistance (the person who assist to fill in this form):

_____

Therapist / Assistant Email:

_____

Therapist / Assistant Contact Number:

_____

SECTION C: Family Information on Patient

Next of Kin:_____

Relation to You: _____

Mailing Address (if different from patient): P.O. Box_____Postal Code:_____

Home Phone:

Work Phone:_____Cell Phone: _____

Email:_____

SECTION D: Medical Information of Patient

Type of financial aid being requested:_____

Referral Source:

_____

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Name of your Doctor (in Cayman):_____

Doctor's Location:_____

Phone Number: _____

Date of last visit:_____

Date of next visit:_____

SECTION E: Mental Health Information of Patient

Type of services being requested (please tick the below options):

Individual: ☐ Group: ☐ Family therapy: ☐

Please tick the applicable concerns:

Low Mood: ☐	Generalized Anxiety: ☐	Depression: ☐
Active Suicidal Ideation: ☐	Social Anxiety: ☐	Learning Disability: ☐
Historical Suicidal Ideation: ☐	Obsessive Compulsive Disorder: ☐	Developmental disorder e.g., ASD, ADHD: ☐
Deliberate Self Harm: ☐	Panic Disorder: ☐	Intellectual Disability: ☐
Hopelessness: ☐	Post traumatic stress disorder (PTSD): ☐	Communication disorder: ☐
Helplessness: ☐	Genetic Disorder: ☐	Others (please specify): _____

Diagnosis if known: _____

Date of diagnosis: _____

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Physician who made the diagnosis: _____

Recommendation (evidence-based practice):_____

Recommended number of sessions: _____

Recommended frequency: _____

SECTION F: Employment Information of Patient / Guardian (if patient under 18 yrs old).

Name of Employer: _____

Address:_____Phone Number: _____

Supervisor's Name: _____

If you are unemployed, please state reason for unemployment:

_____

SECTION G: Insurance Information of Patient

Do you have medical insurance? _____

Answer YES or NO. If NO, please state reason:

_____

_____

_____

_____

_____

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If YES, please confirm:

Name of Company:_____

Policy ID: _____

Employee #: _____

Address: _____

Phone Number: _____

Contact Person: _____

What Mental Health treatment does your Insurance cover?

_____

_____

SECTION F: Financial Information of Patient

Please give us additional information as to the reason you are seeking financial assistance:

_____

SECTION H: Other Agencies

Is the applicant or the patient in the care of a Social Worker? _____

If YES, what is your Social Worker's name: _____

Location and phone number where they can be contacted:_____

_____

How long have you had an assigned Social Worker?

_____

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Have you requested financial assistance from other organization(s)? _____

If you answered YES, please list the organization(s) name(s), contact person(s) and phone number(s) below:

_____

_____

As evidenced by my signature below, I declare that to the best of my knowledge all information provided in this application and any supporting documentation to the **Alex Panton Foundation** is true and complete:

_____ _____ _____

Patient or Applicant's Signature Patient or Applicant's Name

_____

Date (dd/mm/yy)

_____ _____ _____

Witness Signature Witness Name Date

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Authorization for Release of Information

I,_____, authorize_____
(Parent / Guardian / Patient Name) (Psychiatrist / Doctor / Therapist)

to obtain / provide / exchange confidential and cumulative medical records for the patient with The Alex Panton Foundation. This includes permission for transmission of information and data via verbal and electronic contact. These records and information include, but may not be limited to:

- Medical opinions, diagnosis, progress notes, and recommendations
- Treatment plans and progress – including expected duration of treatment and expected treatment plan cost
- Description of treatment and prescriptions

I understand the purpose of this disclosure is to support the patient's access to financial assistance from the Alex Panton Foundation.

This authorization expires on:_____, or when The Alex Panton Foundation is no longer providing the patient with financial support.

Print Patient Name:_____

Patient: D.O.B. _____

Signature of Patient / Parent / Guardian: _____

Date: _____(mm/dd/yy)

Print Witness Name: _____

Signature of Witness: _____

Date: _____(mm/dd/yy)