Alex Panton Foundation's Financial Assistance Programme

Financial Aid Request Form A (Clinical Information) - Introduction and Disclaimer

Alex Panton Foundation's Financial Assistance Programme

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of financial circumstances after assistance has been provided may result in assistance being denied or terminated or withdrawn without further notice.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. All application submissions must include the **recommended treatment plan** (including expected duration and number of sessions for the recommended services) and **cost plan** (a formal quote for the recommended treatment and services).

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.

TERMINOLOGY LIST

Applicant
The individual applying for financial aid. In cases where the Patient is financially independent, the Applicant may also be the Patient. In cases where the Patient is a dependant, the Applicant is an individual financially responsible for the Patient.

Cost Plan
A formal quote or estimate submitted by the Partner Service Provider which details the estimated costs based on the recommended number of sessions and services.

Patient
The individual in need of treatment. In cases where the Patient is financially independent, the Patient may also be the Applicant. In cases where the Patient is a dependant, an individual financially responsible for the Patient must be the Applicant.

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PLEASE ANSWER ALL QUESTIONS FULLY. IF A QUESTION IS NOT APPLICABLE TO YOU, PLEASE ANSWER "N/A". IF YOU NEED MORE SPACE, PLEASE USE THE SPACE PROVIDED ON THE "ADDITIONAL INFORMATION" PAGE (#).

SECTION A: Patient Information

Applicant Name: ____

Patient Name (if different from Applicant): ______________________________

Relation to Patient: ____

Gender (tick where appropriate): ☐ Male ☐ Female ☐ Non-Binary

D.O.B. (DD/MM/YYYY): ______________________________

Applicant Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Patient Residency Status: ☐ Caymanian ☐ Permanent Resident ☐ Work Permit Holder

Do you have any additional needs? ☐ Yes ☐ No

If "Yes", please describe: ____

Mailing Address: Box: _______ Island: ________________ Postal Code: ___________

Physical Address: #: ______ Street: _____________________ District: _____________

Please provide directions to your home:

____

____

Home Phone: _____________ Work: _____________ Cell: _____________

Email: ____________________________________

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SECTION B: Service Provider Information

Service Provider Name: ____

Service Provider Address: ____

Name of Therapist / Assistant (i.e.: the individual who assisted in completing this form):

____

Therapist / Assistant Email: ____

Therapist / Assistant Contact Number: ____

SECTION C: Patient Family Information

Next of Kin Name: ____

Relation to Patient: ____

Mailing Address (if different from Patient):

Box: _______ Island: ____________________ Postal Code: __________

Home Phone: _______________ Work: _______________ Cell: _______________

Email: ____

SECTION D: Patient Medical Information

Type of Financial Aid Being Requested: ____

Referral Source: ____

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Name of Patient's Doctor (in the Cayman Islands): ______________________________

Doctor's Location: ______________________________

Contact Number: ______________

Date of Last Visit (DD/MM/YY): ______________

Date of Next Visit (DD/MM/YY): ______________

SECTION E: Patient Mental Health Information

Type of services being requested (please tick all that apply):

☐ Individual ☐ Group ☐ Family Therapy

Please tick the applicable concerns:

Active Suicidal Ideation: ☐	Communication Disorder: ☐	Deliberative Self Harm: ☐
Depression: ☐	Development disorder e.g., ASD, ADHD: ☐	Generalised Anxiety: ☐
Genetic Disorder: ☐	Helplessness: ☐	Historical Suicidal Ideation: ☐
Hopelessness: ☐	Intellectual Disability: ☐	Learning Disability: ☐
Low Mood: ☐	Obsessive Compulsive Disorder: ☐	Panic Disorder: ☐
Post-Traumatic Stress Disorder: ☐	Social Anxiety: ☐	Other (please specify): ☐

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Diagnosis if known: ____

Date of diagnosis: ____

Physician who made the diagnosis: ____

Recommendation (evidence-based practice): ____

Recommended number of sessions: ____

Recommended frequency: ____

SECTION F: Patient Insurance Information

Do you have medical insurance? ☐ Yes ☐ No

If "No", please state reason:

____

____

____

If "Yes", please provide:

Insurance Company Name: ____

Policy ID: ______________________________

Employee #: ______________________________

Address: ______________________________

Phone Number: ______________________________

Contact Person: ______________________________

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What mental health treatment does your insurance cover?

____

____

SECTION G: Other Agencies

Is the Patient in the care of a Social Worker? ☐ Yes ☐ No

If "Yes", please state Social Worker's name: ____

Address: ____ Phone Number: _____________________

How long have you had an assigned Social Worker? ____

Have you requested financial assistance from other organisations? ☐ Yes ☐ No

If "Yes" please list the date of request, organisation(s) name(s), contact person(s), and phone number(s) below:

____

____

If "No", please specify: ☐ Not eligible ☐ Applied but experiencing delays

☐ Other: ____

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ADDITIONAL INFORMATION

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As evidenced by my signature below, I declare that 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 Signature	Patient or Applicant Name

____

Date (DD/MM/YY)

______________________________	______________________________
Witness Signature	Witness Name

____

Date (DD/MM/YY)

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Request for Financial Aid Form A (Clinical Information)

Authorisation for Release of Information

I, ____, authorise ___________________________________
(Patient / Applicant Name) (Psychiatrist / Doctor / Therapist Name)

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 authorisation expires on ____________________, or when the Alex Panton Foundation is no longer providing the patient with financial support.

Print Patient Name: ____

Patient D.O.B. (DD/MM/YY): ___________________________

Patient / Applicant Signature: ____

Date (DD/MM/YY): _________________________________

Print Witness Name: ____

Witness Signature: _________________________________

Date (DD/MM/YY): _________________________________