



Mental Health JH Program Application

Welcome to the Mental Health JH Program! We are so glad you have found us and you are pursuing your best mental health. This program will provide you with 6 free visits with a participating therapist.

Please fill out the below application and email to Katie Long at the St. John’s Health Foundation at klong@stjohns.health. After emailing the application, you will be expected to hear from Katie Long within 72 hours if your funding is approved. Once you have received an email confirming your funding, please show your therapist the confirmation receipt. If you need to be connected to a therapist, please check the box below and we can help connect you.

Name: _____

Phone: _____

Email/Mailing Address: _____

Date: _____

Employment Status:

_____ Unemployed, no insurance

_____ Unemployed, insurance (Does your insurance cover mental health counseling? Yes____ No____ Not Sure____)

_____ Employed, no insurance

_____ Employed, insurance (Does your insurance cover mental health counseling? Yes____ No____ Not Sure____)

_____ Other

_____ Medicare

_____ Medicaid

Demographic Info:

Male/Female/Prefer Not To Say: _____

County of Residence: _____

Ethnicity/Prefer Not To Say: _____

*Demographic information, other than county of residence, will not be considered with respect to eligibility for services.



Age Group:

___ 0-5 ___ 40-49
___ 6-12 ___ 50-59
___ 13-18 ___ 60-69
___ 19-29 ___ 70-79
___ 30-39 ___ 80+

Industry:

___ Health Care ___ Hospitality & Restaurant Industry
___ Education, Human Services ___ Bank, Office
___ Emergency Services ___ Construction or Transportation Industry
___ Professional Services ___ Retail (Includes Small Business, Grocery, Clothing, etc.)

Primary Language Spoken:

___ English ___ Spanish ___ Other: _____

Presenting Issue at time of request:

___ Mood Disorders ___ Anxiety/Stress
___ Substance Use Disorder ___ Domestic Violence/Sexual Assault/Stalking
___ Phase of Life Issue ___ Parenting Issues
___ Anger/Violence Issues ___ Bipolar Disorder
___ Psychotic Disorder ___ Other

Therapist name:

_____ OR I need a therapist _____

Internal Use:

Does the therapist mentioned above have Participation Agreement on file?

Yes _____ or NO _____



I hereby attest that I 'm seeking assistance through the Mental Health JH Program (the "Program") and will at all times abide by the requirements and restrictions of the Program, including:

- I acknowledge that none of the Program, or St. John's Health Foundation ("Sponsor"), are health care providers or "covered entities" within the meaning of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and that, although Mental Health JH and/or the Sponsor will use reasonable efforts to keep the information in this Application confidential, the confidentiality protections of HIPAA do not apply, and the information may be further used or disclosed by the Program or a Sponsor as required or permitted by law.
- I authorize Mental Health JH and/or a Sponsor to disclose the Application information to mental health professionals participating in the Program (each a "Participating Provider") in order to facilitate my participation in the Mental Health JH program.
- I understand and agree that neither Mental Health JH nor any Sponsor is responsible for providing health care services, or the actions of any Participating Provider, including any professional liability. I will indemnify and hold harmless the Program and each Sponsor from any claim or damages suffered by me or any person claiming by or through me, as a result of my participation in the Program and/or treatment by a Participating Provider.
- I understand and agree that submitting an application does not mean I am either eligible to participate or accepted into the Program, and that my participation in the Program is limited by the Program's available funds, which may run out at any time and which may prevent me from receiving further services, without notice.

Signature: _____

Printed Name: _____ Date: _____

Submit applications to Katie Long at klong@stjohns.health or call 307/739-7506

St. John's Health Foundation
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