OFFICE USE ONLY	
Applicant ID #:	_____
Date Received:	_____
Date Processed:	_____

(Please read this page before filling out the application)

HILLTOP CARES FOUNDATION

PROCEDURES FOR APPLYING FOR BENEFITS

The following information will help you in filling out the attached form to apply for benefits from The Hilltop Cares Foundation. Please complete an application form and sign the attached Notice of Privacy Practices for Applicant/Beneficiary Confidential and Medical Information. The application will be reviewed by the [Benefits Committee] in accordance with the Privacy Practices. Initial where indicated on the form to indicate that you have read this page.

After your application has been accepted (in whole or in part) your verified costs will be paid and/or reimbursed when we receive the following:

- An **acknowledgment that you have received a copy of the Hilltop Cares Foundation Privacy Notice** and have had a chance to ask questions about how Hilltop Cares Foundation will use and share your personal and health information;
- An **Applicant Medical Report** completed and signed by your provider(s);
- Any other information necessary to verify your treatment costs requested by Hilltop Cares Foundation, including but not limited to past bills and mental health insurance policy documents; and
- An **Agreement to Provide Benefits** executed by Hilltop Cares Foundation and countersigned by applicant.

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HILLTOP CARES FOUNDATION

APPLICATION FOR BENEFITS

_____ I have read and understand the attached "Procedures for Applying for Benefits."

SECTION I – BACKGROUND INFORMATION			
NAME OF APPLICANT (Last, First, Middle)			DATE OF BIRTH
YEARS ATTENDED HORACE MANN SCHOOL **from (Month / Year)** _____ **to (Month / Year)** _____			
ADDRESS		CITY STATE	ZIP CODE
EMAIL ADDRESS	HOME TELEPHONE NUMBER	OTHER CONTACT TELEPHONE NUMBERS	

SECTION II – MENTAL HEALTH STATUS

Do you have mental health insurance? ☐ **Yes** ☐ **No**

Do you currently have a therapist? ☐ **Yes** ☐ **No**

If not, do you need help finding a therapist? ☐ **Yes** ☐ **No**

SECTION III –FUNDING REQUESTED

I am requesting funding for the following mental health treatment(s): (Please check treatment boxes and initial your understanding of requirements).

☐ **Payment** of therapy expenses.

_____ I understand that the amount of payment will be determined solely by Hilltop Cares Foundation and will in no case exceed the cost of such therapy after insurance.

_____ I understand that Hilltop Cares Foundation may accept my application for all or any part of the above and that such funding is subject to execution of a formal agreement for funding between me and Hilltop Cares Foundation.

APPLICANT'S SIGNATURE	DATE