FELLOWSHIP

Employee Mental Health & Wellness Incentive Request Form

Employee Name:_____

Benefit Selection: *Please select one of the following options:*

☐ **Reimbursement** – I have already paid for a mental health or wellness service and request reimbursement.

Amount Requested (Maximum $1,500 per year):

$ _____

Date(s) of Appointment(s) **must be within the current calendar year*:

_____

☐ **Advance Payment** – I am requesting an advance payment to cover an upcoming mental health or wellness service. The available benefit will be prorated based on the number of months remaining in the calendar year.

# of months remaining in calendar year _____

Amount Requested (Max $1,500 per year; up to $375 per quarter):

$ _____

Date(s) of Scheduled Appointment(s) **requires follow-up attestation that the appointment occurred*

_____

Employee Certification:
I certify that the information provided is accurate and that the requested benefit will be used for eligible mental health and wellness services as per Fellowship's Mental Health and Wellness Plan policy.

Signature: _____
Date: _____

For HR Use Only:
YTD Amount $ _____Payroll Date: _____
Notes: _____