CARE and COUNSELING

Hope and *Healing*

Client Assistance Fund Application

Instructions

Please bring your completed application and proof of income to your first appointment. Sources for the proof of income must be current, and may include a tax return, pay stub, or letter from your employer.

What is the Client Assistance Fund?

The Client Assistance Fund is a way Care and Counseling provides affordable counseling to those without health insurance or to those who may have difficulty affording the services. While every client is required to pay a fee for counseling services, the Client Assistance Fund is a subsidy that reduces the portion you are required to pay.

Who provides funds for the Client Assistance Fund?

Every year, the Care and Counseling Board of Directors engages in a variety of fundraising activities to support the Client Assistance Fund. Congregations, corporations, foundations, and individuals in our community offer contributions in support of our mission. We do not receive funds from United Way or support from any government program.

How are fees established?

Fees are established by considering net income, household size, and other financial resources. The fee for your first appointment is determined by our Client Service Specialist during the intake process. At the first appointment, you and your therapist will review the application, including the proof of income, discuss any related financial issues, and establish the ongoing appointment fee. Please note the fee may be adjusted when there is a change in your financial status.

What should I consider in applying for the Client Assistance Fund?

- Do I have a savings account, investments, or other assets I could use to pay for therapy?
- Do I have a family member who can provide financial support to my therapy?
- Do I have an employer or congregation that would be willing to contribute to my therapy?

Terms and Conditions

By applying for the Client Assistance Fund, I acknowledge that:

- I do not have health insurance that provides mental health coverage.
- I will immediately notify my therapist if there is a change in my health insurance or financial status.
- My application will be reviewed at least annually, and new proof of income will be required. My fee may be adjusted if my financial circumstances change.
- I will be charged my established fee for appointments missed or cancelled without a 48-hour cancellation notice. This fee must be paid before or at the time of the next appointment. Three incidents of this may result in a termination of the provision of assistance from the Client Assistance Fund.

We welcome you to ***Care and Counseling***, a private, non-profit organization established in 1968. Our mission is to enhance emotional, relational, and spiritual well-being through quality and affordable counseling, professional training, and community education. We have several facilities located throughout the St. Louis metropolitan area, making access convenient for you. Our staff of counselors work with individuals of all ages, couples, and families who are struggling with a wide range of problems and situations. We are prepared and eager to serve you. Furthermore, we want counseling to be financially accessible. Therefore, we have established our Client Assistance Fund to enable you to gain access to the services you want to make the changes you desire.

Client Assistance Fund Application

CLIENT: _____ **DATE:**_____

A) TOTAL NET HOUSEHOLD INCOME PER YEAR $_____

B) LIST ALL SOURCES OF INCOME (i.e. wages, disability, social security).

Source of Income	Amount	Source of Income	Amount
1_____	_____	4_____	_____
2_____	_____	5_____	_____
3_____	_____	6_____	_____

C) LIST ADDITIONAL SOURCES OF FINANCIAL SUPPORT FOR THERAPY (i.e. congregation, family, employer).

1_____ 3_____

2_____ 4_____

D) HOUSEHOLD SIZE

Total # in Household _____ # of Dependents_____

E) PLEASE EXPLAIN ANY OTHER SIGNIFICANT FINANCIAL FACTORS.

_____

_____

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_____

Please review the information about the Client Assistance Fund attached to this application and provide your signature below, indicating:

I have read the terms and conditions of the Client Assistance Fund and declare that all the information I have provided in this application is true and accurate to the best of my knowledge. I understand that misrepresentations or incorrect information given to Care and Counseling may affect the financial assistance I receive and result in increased fees.

_____

Client or Parent/Legal Guardian Signature Date

FOR COUNSELOR USE

A) CLIENT FEE: _____

B) RATIONALE FOR FEE: _____

_____

_____

_____

Counselor Signature Date