The Center
for Integrative Counseling
and Psychology

TheCenterCounseling.org

North Texas 214.526.4525
Central Texas 254.732.2006

06.2019

Financial Assistance Application

Date: _______________ If Client is a minor: Name (First, Last) ______________________________

CLIENT/RESPONSIBLE PARTY INFORMATION:

First Name: ____________________ Middle Name or Initial: __________ Last Name: _____________________

Address: ____

City: ______________________________ State: _______ County: _____________ Zip Code: ____________

Birth Date: __________________________ SS#: _________________________

Cell phone: ___________________________________ Home phone: ________________________________

Employed? ❑ Yes ❑ No

Employer: ___________________________________ Work phone: ____________________ Ext: _________

If unemployed, please include the previous employer's name and telephone number.

RELATIONSHIP STATUS:

❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widow/Widower

Spouse's Name (if applicable): ____

Spouse employed? ❑ Yes ❑ No

Spouse's employer: _______________________________ Work phone: _________________ Ext: ________

If unemployed, please include the previous employer's name and telephone number.

INCOME:

Please provide the income for each of the following persons in your household. If client is a minor, please complete this information for both parents.

Client/Parent 1: ❑ Full time ❑ Part time – Hours/Week = _____

$ ________ ❑ Hour ❑ Week ❑ Bi-Weekly ❑ Monthly ❑ Yearly

$ _________ Additional Income

Spouse/Parent 2: ❑ Full time ❑ Part time – Hours/Week = _____

$ ________ ❑ Hour ❑ Week ❑ Bi-Weekly ❑ Monthly ❑ Yearly

$ _________ Additional Income

Total Household Income: $ _____________

INCOME VERIFICATION:

Please provide verification (only copies, no original documentation) for all sources of household income (acceptable documentation listed below). Check attached documents.

❑ IRS Form W-2 ❑ Paycheck Remittance ❑ Tax Return ❑ Bank Statements

❑ Employer Verification ❑ Governmental Assistance (food stamps, CDIC, Medicaid, TANF)

❑ Social Security, Workers Compensation or Unemployment Compensation Determination Letters

❑ Other (describe) ____

If you are unable to provide one of the sources of income documentation described above, please explain why this information is not available: ____

____

FAMILY MEMBERS:

Please provide the total number of people in the household. [ ]

(This number should only include the client (or parent), client/parent's spouse, and the client/parent's dependents.)

ASSETS AND OTHER RESOURCES:

Dou you have any assets or other resouces available to you?

(Examples include savings accounts, trusts, stocks, bonds, retirement accounts, mutual funds, etc.)

❑ Yes ❑ No If Yes, current amount available: $ __________

Do you have medical insurance?

❑ Yes ❑ No If Yes, please list provider name: ________________________

Do you have a Health Savings or Flexible Spending Account?

❑ Yes ❑ No If Yes, current amount available: $ __________

I understand The Center for Integrative Counseling and Psychology (The Center) may verify the financial information contained in this Financial Assistance Application (Application) in connection with The Center's evaluation of this Application, and by my signature hereby authorize my employer or any individual listed on this Application to certify or provide additional details with respect to the information provided in this Application. I also authorize The Center to request reports from credit reporting agencies and the Social Security Administration. I certify that the statements made in this Application are true and correct, to the best of my knowledge and belief, and are made in good faith. I am aware that falsification or misrepresentation of information on this Application may result in denial of financial assistance.

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Signature of Client or Responsible Party Printed Name Date