

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:

Do you have any assets or other resources 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.

Signature of Client or Responsible Party

Printed Name

Date