SLIDING SCALE APPLICATION

If you are not able to pay the $90 fee per counseling sessions you can apply for a discounted fee based upon your income. Please complete this form in its entirety and return it to Wellspring before your first visit in order to avoid having to pay the full fee for services. A Wellspring representative will review this application for reduced fee services and contact you regarding your approved discount. Approval of the sliding scale fee only applies to sessions not yet completed. Clients are expected to pay the full $90/session for all sessions completed before approval of the sliding scale application.

Availability of reduced fee therapy sessions is dependent upon a number of factors, including staff availability, number of sessions expected to be required, and availability of Client Assistance funds.

#1 Household Information

Name: ____ Number of people in your household ______

Primary Phone __________________________ Email: ______________________________________

#2 Church Affiliation:

Are you attending a local church? Yes No ***(if no, skip to #3)***

ﬂ yes, which church are you attending? ____

If yes, have you asked them for financial assistance with your counseling fees? Yes No

If you have a home church and have not asked them for assistance, we can contact them for you. We have partnerships with several local churches that are able to help with members from their church who need assistance.

Comments:____

____

#3 Financial Information:

Are you currently employed? Yes No

If yes, who is your employer? ____

What is your annual household income (please include everyone in your household who has income including disability, child support etc.)*? ______________________

Please explain why you need financial assistance with your counseling fees:

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I attest that the information disclosed above is true and accurately reflects my current financial situation and that I do not have adequate personal resources that may be utilized to meet my fees for counseling services.

Applicant Signature: _____________________________________ Date:_______________

Consent for Release of Information for Churches

Name of Client: ___________________________________ **Date of Birth:** __________

Parent/Guardian Giving Consent (if applies): ___________________________________

I hereby authorize the following release of information to:

____
Name of Church

Address:____

City, State, Zip:____

For the Purpose of (Please Initial all that apply):

_______ Wellspring Counseling Center requesting financial assistance as well as financial information on my behalf to the above, mentioned entity.

________Other: ____

I release Wellspring Counseling Center of any and all liability regarding the use of information which I have authorized for release. The State of Indiana (16-39-2-5) restricts consent to release information to a 180 day period following the date of my signature. I understand my consent is terminated when the purpose of the release is fulfilled. I may cancel my consent at any time with a written statement requesting such action. However, my cancellation does not affect past action already taken with any such information that was released with my consent.

It is understood the information released is for professional use only and may not be provided in whole or in part to any other agency or individual other than those stated above. Federal regulation (42-C.F.R. PT.2) prohibits further disclosure without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

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Signature of Client or Guardian *Date*

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Client or Guardian Street Address *City, State* *Zip*