CornerstoneVision Counseling (CVC) and Psychological Services
FEE ASSISTANCE APPLICATION

Note: Please be sure to complete separate applications for each person in your home that is a client at CVC.

Client Name: ___________________________________ Spouse (if applicable) ______________________

Address: ____________________________________ Home Phone #: ___________________________

CSZ: ____ Work Phone #: ____________________________

Does your household have a trust, inheritance, stock, savings that is **accessible** or cash in excess of $5,000 (excluding IRA)? _____Yes _____No

Do you have primary or secondary insurance available to your family that covers counseling/psychological services with the therapist that you are scheduled to see at CV? _____Yes_____ No

If "Yes," you must either use your insurance or pay at the full fee rate.
Note: It is considered fraud to use the adjusted fee schedule when insurance/mental health benefits are available.

Are there additional reasons/circumstances you should be considered for a reduced fee? (ex. large medical or legal expenses)

TOTAL NUMBER OF PERSONS IN HOUSEHOLD: _____________________
If you are over the age of 18, but still living with your parents this number would be you and any of your dependents, not parents or siblings.

TOTAL **ANNUAL** HOUSEHOLD INCOME **AFTER TAXES**: $_____________________
(including Unemployment, Disability, Social Security etc.)

If applicable: Child support paid out/received yearly: (please circle which) $_____________________

MINISTERIAL HOUSING/PARSONAGE ALLOWANCE (if applicable) $ ____________________

PLEASE ATTACH COPIES OF TWO OF YOUR MOST RECENT PAY STUBS OR LAST YEARS COMPLETE TAX RETURN FOR EACH HOUSEHOLD WAGE EARNER FOR VERIFICATION.
In most cases, reduced fees will be limited to twelve (12) sessions.

☐ I UNDERSTAND THAT ALL REDUCED FEES MUST BE PAID AT THE TIME OF SERVICE. (Please initial box)

We (I) declare that we (I) have reviewed the information above; and to the best of our (my) knowledge and belief, it is true, correct, and complete. Furthermore, I understand this agreement is based on not having any insurance benefits covering these mental health services.

Signed: ____ Date: ____________________________

Approval Date: _________________________________	Fee: $_____________________
Effective Date: _________________________________	Approved By: ___________________

Client #: ___________________