Reduced Fee Application

The Foundation Counseling Center exists to reflect the heart of Christ by offering hope and healing to families and individuals, regardless of income. Our reduced fee program is available for people who are experiencing financial hardship and in need of a short-term cost reduction for services. In order for us to provide you with financial aid for counseling, please complete the following application. Applications are reviewed weekly and we reserve the right to deny applications that are incomplete and/or inaccurate.

Personal Information

Client Name: _____ ***Phone***:_____
□ This is my first application □ I am reapplying

Financially Responsible Person (if applying for a minor): _____

Address:_____

Counselor(s) Name: _____

If this application is for a minor, please have them fill out the following written questions when appropriate

On a scale of 1 to 10, with 1 being the least distressing and 10 being the most distressing, how would you rate the issue(s) for which you are seeking counseling? _____

What gifts, capabilities, and talents do you or others say you have?

_____

_____

What are your dreams for the next 6 months?

- *Financially:* _____
- *Intellectually:*_____
- *Emotionally:* _____
- *Spiritually:*_____
- *Relationally:* _____

How would you like your life situation to be different or improved 4 months from now?

_____

_____

Goal 1: _____

Goal 2:_____

What are some strengths and abilities you have that can help you get to where you want to be?

_____

_____

What obstacles do you see preventing you from achieving your goals?

_____

_____

Who is, or could be, in your support system?

_____ _____ _____

Living Situation: □ Roommate(s) □ Single □ Married □ Separated □ Divorced □ With parent(s) □ Cohabitating and unmarried
Number of children and/or dependents under your care:_____

Housing Status: □ Own □ Owe payment(s) □ Behind on monthly payments □ Foreclosure □ Short Sale □ Bankruptcy
□ Rent □ Homeless □ Other

I receive financial assistance from: □ Family □ Medicaid □ WIC/SNAP □ SSI/SSDI □ College Aid □ Child Support
□ Unemployment □ Food Bank □ Church □ Other

Monthly Living

Please indicate the amount you spend or receive <u>MONTHLY</u> on the following:

Rent/Mortgage	
Car Insurance	
Taxes	
Utilities	
Cable & Phone	
Gas & Tolls	
Groceries	
Child Care	
Health Insurance	
Car Payments	
Credit Card Payments	
Medical Bills & Medications	
Others:	
TOTAL MONTHLY EXPENSES	

Wages (Yourself)	
Wages (Your Spouse)	
Child Support	
Alimony	
Savings	
Investments	
Other Household Income	
TOTAL MONTHLY INCOME	

Total Monthly Income
<u>–Total Monthly Expenses</u>

$

I pledge to cut-back/sacrifice on _____ in order to keep coming to counseling.

By signing below, I acknowledge that the information provided above is accurate to the best of my knowledge and complete. I understand I will need to reapply in 6 months if further assistance is needed.

Signature: _____ ***Date:*** _____

FOR OFFICE USE ONLY

Current Application:
Date:_____
□ Denied □ Approved Approved By:_____Client Pays: _____ Write-off Amount: _____ Renewal Date: _____
□ Scanned □ Attached to Client File