CHARITABLE GRANT APPLICATION

Patient's Name:_____ DOB:____/____/____

Is patient covered by medical insurance? **Y / N** Plan carrier / name: _____

Does the insurance plan have mental health benefits? **Y / N**

If Yes, please provide the following information: Unmet Deductible, if any:_____

Rate of reimbursement for out-of-network provider:_____

Household Income[1]:_____ Persons In The Family[2]:_____

NOTE: The following tables provide **suggested guidelines** for Charitable Grants. You may request amounts different from these. The amounts in the tables refer to how much would be **deducted** from the Standard Fee for that service and are subject to change. If approved, you would be responsible for the **remainder** after subtracting the Grant amount from the Standard Fee.

Initial Session (90 min.) Standard Fee: $320					
	Persons In The Family[2]				
Household Income[1]	1	2	3-4	5-6	7+
$0 - $25,000	$110	$120	$135	$150	$160
$25,000 - $35,000	$70	$80	$85	$95	$100
$35,000 - $50,000	$40	$50	$55	$65	$70
$50,000 - $65,000	$20	$25	$30	$35	$40
$65,000 - $80,000	N/A	$20	$25	$30	$35
$80,000 - $95,000	N/A	N/A	$20	$25	$30

Regular Sessions (50 min.) Standard Fee: $160					
	Persons In The Family[2]				
Household Income[1]	1	2	3-4	5-6	7+
$0 - $25,000	$90	$95	$100	$105	$110
$25,000 - $35,000	$80	$85	$90	$95	$100
$35,000 - $50,000	$50	$60	$70	$75	$80
$50,000 - $65,000	$30	$40	$50	$60	$65
$65,000 - $80,000	N/A	$30	$40	$45	$50
$80,000 - $95,000	N/A	N/A	$30	$35	$40

[1] "Household Income" is the Adjusted Gross Income as reported on your most recent federal income taxes. For couples and families, this must include the combined income of all contributing spouses / partners. Please attach a proof of income to this application (e.g., most recent payroll statement or the first page of your most recent federal income tax form).

[2] "Persons in the Family" refers to the spouses/ partners and any dependent children. If the patient is a child, this refers to any residential parents / step-parents and other dependent children that are part of the household.

Group Therapy Sessions (90 min.) Standard Fee: $100					
	Persons In The Family[2]				
Household Income[1]	1	2	3-4	5-6	7+
$0 - $25,000	$50	$55	$60	$65	$70
$25,000 - $35,000	$40	$45	$50	$55	$60
$35,000 - $50,000	$25	$30	$35	$40	$45
$50,000 - $65,000	$10	$15	$20	$25	$35
$65,000 - $80,000	N/A	$10	$15	$20	$25
$80,000 - $95,000	N/A	N/A	$10	$15	$20

I hereby request the following:

	Grant Amount	Remaining Fee
Initial Session (standard fee = $320):	$	$
Regular Sessions (standard fee = $160):	$	$
Group Therapy Sessions (standard fee = $100):	$	$

Please provide a brief rationale for why you need this financial assistance and how you will put it to use:

_____

_____

_____

_____

By signing below, I attest that the information I have included in this application is true and accurate. I also agree, if my application is approved, to promptly pay the Remaining Fee for any services I receive at RWPS, and I will not allow an unpaid balance to accrue. If my financial circumstances change, I will promptly inform my therapist and/or complete a new Grant Application. Lastly, I agree to make my best effort to utilize the services I am provided to make positive changes in my life according to the goals that my therapist and I formulate.

_____ _____

Signature of Patient (or parent/guardian) Date

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☐ Income Verified ☐ Family Size Verified Grant Amounts and rationale seem reasonable? Y / N

Approval:

_____ _____

Andrew J. Sodergren, Psy.D. Date