



CHARITABLE GRANT APPLICATION

(Masters-level Providers: Rod Dunlap, MA, IMFT; Alex Wallace, MA, LPCC)

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 Income¹: _____ Persons In The Family²: _____

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: \$280					
	Persons In The Family ²				
Household Income ¹	1	2	3-4	5-6	7+
\$0 - \$35,000	\$115	\$120	\$125	\$135	\$140
\$35,000 - \$45,000	\$95	\$100	\$105	\$110	\$115
\$45,000 - \$55,000	\$75	\$80	\$85	\$90	\$95
\$55,000 - \$70,000	\$55	\$60	\$65	\$70	\$75
\$70,000 - \$85,000	\$30	\$35	\$40	\$45	\$50
\$85,000 - \$100,000	\$10	\$15	\$20	\$25	\$30

Regular Sessions (45-50 min.) Standard Fee: \$140					
	Persons In The Family ²				
Household Income ¹	1	2	3-4	5-6	7+
\$0 - \$35,000	\$90	\$95	\$95	\$100	\$100
\$35,000 - \$45,000	\$80	\$80	\$85	\$85	\$90
\$45,000 - \$55,000	\$65	\$70	\$75	\$80	\$80
\$55,000 - \$70,000	\$45	\$50	\$55	\$65	\$65
\$70,000 - \$85,000	\$30	\$35	\$40	\$40	\$45
\$85,000 - \$100,000	\$10	\$15	\$20	\$25	\$30

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 - \$35,000	\$50	\$55	\$60	\$65	\$70
\$35,000 - \$45,000	\$40	\$45	\$50	\$55	\$60
\$45,000 - \$55,000	\$25	\$30	\$35	\$40	\$45
\$55,000 - \$70,000	\$10	\$15	\$20	\$25	\$35
\$70,000 - \$85,000	N/A	\$10	\$15	\$20	\$25
\$85,000 - \$100,000	N/A	N/A	\$10	\$15	\$20

I hereby request the following:

	Grant Amount	Remaining Fee
<u>Initial Session</u> (standard fee = \$280):	\$	\$
<u>Regular Sessions</u> (standard fee = \$140):	\$	\$
<u>Group Therapy Sessions</u> (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

For Office Use Only

Income Verified Family Size Verified

Grant Amounts and rationale seem reasonable? Y / N

Approval:

Andrew J. Sodergren, Psy.D.

Date

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