

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: \$290 | | | | | |
|-----------------------------------------------|------------------------------------|-------|-------|-------|-------|
| | Persons In The Family ² | | | | |
| Household Income ¹ | 1 | 2 | 3-4 | 5-6 | 7+ |
| \$0 - \$35,000 | \$120 | \$125 | \$130 | \$140 | \$145 |
| \$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 | \$35 | \$40 | \$45 | \$50 | \$55 |
| \$85,000 - \$100,000 | \$15 | \$20 | \$25 | \$30 | \$35 |

| Regular Sessions (45-50 min.) Standard Fee: \$145 | | | | | |
|---------------------------------------------------|------------------------------------|------|------|------|------|
| | Persons In The Family ² | | | | |
| Household Income ¹ | 1 | 2 | 3-4 | 5-6 | 7+ |
| \$0 - \$35,000 | \$80 | \$85 | \$85 | \$90 | \$90 |
| \$35,000 - \$45,000 | \$65 | \$70 | \$70 | \$75 | \$80 |
| \$45,000 - \$55,000 | \$50 | \$55 | \$55 | \$60 | \$65 |
| \$55,000 - \$70,000 | \$35 | \$40 | \$40 | \$45 | \$50 |
| \$70,000 - \$85,000 | \$25 | \$30 | \$30 | \$35 | \$35 |
| \$85,000 - \$100,000 | \$15 | \$15 | \$25 | \$20 | \$25 |

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: \$110 | | | | | |
|------------------------------------------------------|------------------------------------|------|------|------|------|
| | 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 = \$145): | \$ | \$ |
| <u>Group Therapy Sessions</u> (standard fee = \$110): | \$ | \$ |

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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