



CHARITABLE GRANT APPLICATION

(Masters-level Providers)

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

RWPS Therapist(s): _____

Is patient covered by medical insurance? **Y / N** Does plan include mental health benefits? **Y / N**

Name of plan: _____ Amount Unmet Deductible, if any: _____

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

Household Income¹ (attach proof of income): _____ 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: \$300					
	Persons In The Family ²				
Household Income ¹	1	2	3-4	5-6	7+
\$0 - \$40,000	\$120	\$125	\$130	\$140	\$145
\$40,000 - \$50,000	\$95	\$100	\$105	\$110	\$115
\$50,000 - \$60,000	\$75	\$80	\$85	\$90	\$95
\$60,000 - \$75,000	\$55	\$60	\$65	\$70	\$75
\$75,000 - \$90,000	\$35	\$40	\$45	\$50	\$55
\$90,000 - \$105,000	\$15	\$20	\$25	\$30	\$35

Regular Sessions (45-50 min.) Standard Fee: \$150					
	Persons In The Family ²				
Household Income ¹	1	2	3-4	5-6	7+
\$0 - \$40,000	\$80	\$85	\$85	\$90	\$90
\$40,000 - \$50,000	\$65	\$70	\$70	\$75	\$80
\$50,000 - \$60,000	\$50	\$55	\$55	\$60	\$65
\$60,000 - \$75,000	\$35	\$40	\$40	\$45	\$50
\$75,000 - \$90,000	\$25	\$30	\$30	\$35	\$35
\$90,000 - \$105,000	\$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: \$115					
	Persons In The Family ²				
Household Income ¹	1	2	3-4	5-6	7+
\$0 - \$40,000	\$50	\$55	\$60	\$65	\$70
\$40,000 - \$50,000	\$40	\$45	\$50	\$55	\$60
\$50,000 - \$60,000	\$25	\$30	\$35	\$40	\$45
\$60,000 - \$75,000	\$10	\$15	\$20	\$25	\$35
\$75,000 - \$90,000	N/A	\$10	\$15	\$20	\$25
\$90,000 - \$105,000	N/A	N/A	\$10	\$15	\$20

I hereby request the following:

	Grant Amount	Remaining Fee
<u>Initial Session</u> (standard fee = \$300):	\$	\$
<u>Regular Sessions</u> (standard fee = \$150):	\$	\$
<u>Group Therapy Sessions</u> (standard fee = \$115):	\$	\$

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. If approved, this charitable grant arrangement will remain valid for the current calendar year. 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:

Michael P. Murphy, Psy.D.

Date

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