



CHARITABLE GRANT APPLICATION

(Masters-level Providers: Maggie Herson, MA, LPC; 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.

Table with 6 columns: Household Income, 1, 2, 3-4, 5-6, 7+. Title: Initial Session (90 min.) Standard Fee: \$290

Table with 6 columns: Household Income, 1, 2, 3-4, 5-6, 7+. Title: Regular Sessions (45-50 min.) Standard Fee: \$145

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 = \$290):	\$	\$
<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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