Ruah Woods PSYCHOLOGICAL SERVICES

CHARITABLE GRANT APPLICATION

(Doctoral-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 Income[1] (attach proof of income)**:**_____ **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: $350					
	Persons In The Family[2]				
Household Income[1]	1	2	3-4	5-6	7+
$0 - $40,000	$140	$150	$160	$170	$180
$40,000 - $50,000	$120	$125	$130	$135	$140
$50,000 - $60,000	$80	$90	$100	$110	$120
$60,000 - $75,000	$60	$65	$70	$75	$80
$75,000 - $90,000	$40	$45	$50	$55	$60
$90,000 - $105,000	$20	$25	$30	$35	$40

Regular Sessions (50 min.) Standard Fee: $175					
	Persons In The Family[2]				
Household Income[1]	1	2	3-4	5-6	7+
$0 - $40,000	$95	$100	$105	$110	$115
$40,000 - $50,000	$80	$85	$90	$95	$100
$50,000 - $60,000	$50	$60	$70	$75	$80
$60,000 - $75,000	$30	$40	$50	$60	$65
$75,000 - $90,000	$25	$30	$40	$45	$50
$90,000 - $105,000	$20	$25	$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: $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
Initial Session (standard fee = $350):	$	$
Regular Sessions (standard fee = $175):	$	$
Group Therapy Sessions (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:

_____ _____

Andrew J. Sodergren, Psy.D. Date

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