The Saluda Counseling Center

Care Fund Application

Date:_____

Client Name:_____Date of Birth:_____ MR#:_____

1) Number of people in household: _____

2) Household Income (Monthly):_____

3) Explanation of Financial Status (i.e.: unusual circumstances or specific stressors):_____

_____

_____

4) Have you been seen at The Saluda Counseling Center before? Yes ☐ No ☐ If yes, when? _____

5) Do you have commercial insurance or Medicare? Yes ☐ No ☐

6) If yes, is mental health covered under your benefits? Yes ☐ No ☐

I have read and understand the Care Fund policy and by signing below I acknowledge that I understand this policy, and that I have reported my total income. I understand that I am required to report any change in income upon this change.

_____ _____

Client's Signature Date

The Saluda Counseling Center

Care Fund Application

Client Name:_____Date of Birth:_____ MR#:_____

For Provider's Use Only:

Provider's Name: _____

Requested number of visits in the next 3 months: _____

Clinical Information (attach a separate sheet if needed):_____

_____

_____

For Administrative Use Only:

Is there a past due balance? Yes ☐ No ☐

If yes, how much is past due? _____

If applicable, has a payment plan been established for this past due balance? Yes ☐ No ☐

Is this the first application for this client? Yes ☐ No ☐ If no, how many times has the client applied? _____

Has the client provided proof of income for this application? Yes ☐ No ☐

Total Amount of Request from Care Fund: $_____ X _____ visits = $_____

Notes:_____

_____

Date Reviewed:

Approved ☐ Denied ☐

Committee Signatures: 1)_____

2)_____

3)_____