Name ____ Date _________________________

Section A: Health Insurance/EAP Information:

1. Primary Insurance Company_________________________ Policy#:____________________________

Telephone # ___________________ ___________________

Name of Primary Policy Holder________________________ Date of Birth_______________________

Social Security No# _______ _________ Employer ____

Annual Deductible Amount $___________Deductible Paid This Year $_____________________________

2. Name of Other Insurance Company _________________ Policy#:_____________________________

Telephone # ___________________ Name of Primary Policy Holder______________________________

Social Security # ______________Date of Birth _________ Employer ____________________________

Annual Deductible Amount $_____________ Deductible Paid This Year $_____________

Insured or Authorized person's signature: I consent and authorize Covenant Counseling & Family Resource Center to release medical or other supporting information necessary to process my insurance claims. I understand that I am responsible for all deductibles and co-pays for my insurance. I understand I am financially responsible for all charges whether or not paid by said insurance including missed appointments. I authorize payment of medical benefits to Covenant Counseling & Family Resource Center for services provided.

Printed Name*:* _____________________ Signature: ________________________Date: ______________

Insured or Authorized Person's Signature of the Minor Client:

Printed Name*:* _________________________________ Relationship________________________________

Signature: ____________________________________Date: ____________________________________

Section B: Determination of Scholarship for Counseling Fees: If you do not have insurance/EAP and cannot afford our full fee for counseling, you may be eligible for a scholarship to receive a reduced fee. Please complete the information below and be prepared to provide proper documentation to verify income.

Part 1 **Monthly Family/Household Income**	Part 2 **Major Exceptional Expenses**
Gross Salary/Wages __________	Major Medical___________
Child Support _____________	Child Care ______________
Retirement ______________	Adult Care ______________
Social Security ______________	Casualty Loss ______________
Rental-Lease Income ________	
Other Income _____________	
Total Household Income _____________	**Total Expenses** _____________

Number of Family Members Income Supports: _______

2010-02-08

Acknowledgement

I have been informed of my reduced fee and understand that I am responsible for paying any balance that I accrue. I understand this reduced fee is a scholarship that is based on current financial information given to the Center at the time of intake. If at any time my financial situation changes, I will inform the Center and supply updated information to be used in the determination of a new fee arrangement. I further understand that if I have accrued a credit balance at the time of service termination, those additional monies on my account will be applied to reimburse the Samaritan Center for any scholarship funds that I have received.

Printed Name*:* ____

Signature: ____ Date: ______________

CCFRC Staff Signature _______________________________________ Date _______________

TO BE COMPLETED BY CCFRC STAFF	
Adjusted Annual Income	_________________
Agreed Upon Fee	_________________

The following information is collected for data purposes only. It will be utilized for grant writing purposes only. You are not required to complete this information.

Ethnicity:

African-American Hispanic Anglo Native American Asian Other ________

Sex: Male Female

Marital Status Single Committed Relationship Married Widowed
Other Divorced

How did you hear about Covenant Counseling Center?

Clergy Insurance Social service Family Doctor Media/ad
Friend School Client Seminary Walk – in
Other: ____

Faith preference_______________________________ Congregation___________________________________

2010-02-08