

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 _____	
<b>Total Household Income</b> _____	<b>Total Expenses</b> _____

Number of Family Members Income Supports: \_\_\_\_\_

**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 \_\_\_\_\_