



## Application for Program Assistance

Questions or concerns about this form must be directed to the Business Manager at (636)-449-1262. To avoid unnecessary delays, **please print clearly** and provide **all** requested information. We require up to 7 business days to verify and process all applications.

Client Name(s): \_\_\_\_\_  
Counselor's Name: \_\_\_\_\_ Date of Application: \_\_\_\_\_  
Church attending: \_\_\_\_\_ Are you a member? YES NO  
Pastor's name \_\_\_\_\_ Church Telephone #: \_\_\_\_\_  
Denomination \_\_\_\_\_

### I. FINANCIALLY RESPONSIBLE PERSON

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Relationship to Client: \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_  
Marital Status (Circle One): Single Married Divorced Separated Widowed  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home phone: ( ) \_\_\_\_\_ Work phone: ( ) \_\_\_\_\_  
Cell phone: ( ) \_\_\_\_\_ E-mail address: \_\_\_\_\_

May we notify you via email about your request? Yes  No

**If e-mail address is not provided, all notifications for Program Assistance will be sent via U. S. mail to the address listed above.**

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## ADDITIONAL POTENTIAL FINANCIAL RESOURCES

### A. YOUR FAMILY

Family members may be a resource to assist with your fees.

### B. YOUR CHURCH

We work with several churches that are very willing to help their members pay for our services. Please contact your church to ask if they have funds available to assist with the cost of counseling fees.

What was their answer?    YES    NO

Name of individual you spoke with at your church: \_\_\_\_\_

### C. YOUR MENTAL HEALTH BENEFITS PLAN

See Appendix A (MENTAL HEALTH INSURANCE)

## II. HOW MUCH DO YOU THINK YOU CAN AFFORD FOR EACH HOUR OF COUNSELING?

\$ \_\_\_\_\_

## III. PERSONAL FINANCIAL INFORMATION

**INCOME** – Please provide the following information for yourself and all adult household members with any source of income.

Name	Employer (Name, address, and telephone)	Gross Annual Income

### DEPENDENT INFORMATION

Name	Employer (Name, address, and telephone)	Gross Annual Income

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**PERSONAL FINANCIAL INFORMATION (continued)**

Any other circumstances we should consider?

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**Additional financial information or responsibilities that should be taken into consideration (please use additional paper if necessary).**

Description of Assets and Liabilities	Current Fair Market Value	Current Amount Owed
Cash (on hand)		
Cash (in banks or credit union)		
Stocks/Bonds		
Real estate:		
Personal home		
Other:		
Automobiles:		
Description:		
Description:		
Description:		
Other personal property:		
Description:		
Description:		
Description:		
Retirement Plans:		
Description:		
Description:		
Other:		
Description:		
Description:		
Description:		

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#### IV. BY SIGNING MY INITIALS BELOW, I UNDERSTAND AND AGREE THAT:

(Any documentation required to process this application will be kept confidential.)

##### A. Tax Return and paycheck stub (both required)

- I will provide a copy of my most recent tax return (1040 and all Schedules) \_\_\_\_\_ (initials)

**AND**

- I will provide a copy of the most recent paycheck stub for all contributing family members \_\_\_\_\_ (initials)

##### B. Changes in information

I acknowledge the above information is true and accurate. I understand that donations from others are used to help offset the cost of my counseling, therefore, if for any reason the information I have provided changes:

- I will contact the **WELLSPRING CHRISTIAN COUNSELING Business Manager immediately to notify them of the changes in my financial status** \_\_\_\_\_ (initials)

##### C. Worship Attendance

I understand that program assistance is contingent upon my attendance at a weekly worship service. I agree that:

- I will attend a weekly worship service while receiving program assistance from the **Wellspring Christian Counseling** \_\_\_\_\_ (initials)

##### D. Program Assistance Notification

I understand that the Business Manager will process my application and notify me of if I qualify for program assistance within 7 business days from the date this completed application is received.

- I will direct all my questions regarding this application to the **Business Manager at 636-449-1262.** \_\_\_\_\_ (initials)

##### E. Program Assistance Submission

I will submit this application (with all requested documentation) directly to the Business Manager (*check one*):

- in person to: Business Manager, Wellspring Christian Counseling, 1400 Elbridge Payne Rd., Suite 200, Chesterfield, MO 63107**
- by mail to: Business Manager, Wellspring Christian Counseling, Elbridge Payne Rd., Suite 200, Chesterfield, MO 63107**
- by fax to: Business Manager at (636) 449-1268**

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**Fee Responsibility**

Until this completed application is received, processed and approved by the Business Manager, I understand that:

- I am responsible for and agree to pay the full service fee for all services provided by Wellspring Christian Counseling at the time of the service**  
\_\_\_\_\_ (initials)

**F. Program Assistance Confidentiality**

In order to honor the integrity of the Program Assistance Program, and to preserve my participation in the Program Assistance Program, I agree that:

- I will not discuss with anyone the amount of the assistance that is awarded to me by Wellspring Christian Counseling** \_\_\_\_\_ (initials)

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Financially Responsible Person

\_\_\_\_\_  
Date

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## APPENDIX A

### MENTAL HEALTH INSURANCE

#### A. Your Insurance Mental Health Benefits

If you have insurance benefits, we require that they be utilized before any Program Assistance Funds can be awarded. Please be aware of the following:

1. You must pay for services at the time of your session(s).
2. Wellspring Christian Counseling does not process insurance claims.
3. A receipt is provided to use in requesting reimbursement from your insurance company; receipts are sent monthly and requests for receipts must be made in writing to the Business Manager ([dpowers@wellspringstl.org](mailto:dpowers@wellspringstl.org)). Please include your name, your counselor's name, and your mailing address.

#### B. Questionnaire

We have prepared the following questionnaire to guide you through the process of gathering information about your insurance benefits. Contact the "Customer Service" department of your insurance company and record their answers to the questions below:

1. Do I have "Behavioral Health" benefits for:  
Individual Counseling?      Yes    No  
Family Counseling?          Yes    No  
Marital Counseling?         Yes    No

If **'NO'** to all of these items, there is no need to continue with this section.

If **'YES'** to any of these items, then proceed with the next question.

2. Do I have coverage for "Out of Network" providers?    Yes    No  
If **'NO,'** then there is no need to continue with this section as the Wellspring Christian Counseling is not on any "Network Provider List."  
If **'YES,'** then proceed with the next question.

3. Does my insurance company:  
Require that I see a Licensed Professional Counselor (LPC)?    Yes    No  
Allow me to see a Provisionally Licensed Professional Counselor (PLPC)?  
Yes    No  
Allow me to see a faith-based counselor regardless of credentials?    Yes    No

4. How many visits am I allowed under the "Out of Network Provider Plan?" \_\_\_\_\_

5. Do I need to be pre-certified prior to making an appointment?    Yes    No  
If yes, what is the pre-certification code assigned? \_\_\_\_\_

6. What is the pre-certification process? Please describe:  
\_\_\_\_\_  
\_\_\_\_\_