Client Assistant Fund Application
(Please read carefully and thoughtfully)

Client Name: _____ Date of Application: _____/_____/_____

What is the Client Assistance Fund (CAF)?

At The Summit Counseling Center, part of our mission is to provide faith-based counseling to people and to make these services available to people who might have difficulty affording them. Financial need can impact any individual or family. Accordingly, the Summit Counseling Center's Client Assistance Fund is available to subsidize a portion of your fee if you are in significant financial need. The CAF does not make counseling "free," but it reduces the portion you are required to pay.

Who provides CAF Funds?

Each year The Summit Society commits to raising the necessary funds through a wide variety of fundraising activities.

TOTAL HOUSEHOLD INCOME PER YEAR (GROSS): $_____

It is the policy of the Summit Counseling Center Board that individuals applying for the Client Assistance Fund **MUST provide verification of income, such as tax return, pay stub, or similar proof.**

Please present this proof with your application.

PLEASE EXPLAIN ANY SIGNIFICANT EXTENUATING FINANCIAL FACTORS:

_____

_____

- I understand that in order to receive financial assistance from the Summit Counseling Center's **Client Assistance Fund,** information about my financial resources will be reviewed by The Summit Counseling Center office staff.
- I understand that my financial status will be reviewed on a regular basis and that my fee may be adjusted when/if my financial circumstances change.
- I understand that CAF Funds DO NOT cover the cost of unexcused missed or cancelled (with less than 24 hours notice) sessions, AND that I will be billed for my co-pay for the session.
- The Summit Counseling Center Board policy is that assistance through this **Client Assistance Fund** be approved for a period of six months, followed by a financial review.
- I further understand that if I use Client Assistance Funds, I **cannot file any claims** with my insurance company. **This is considered insurance fraud.**

_____ _____
Client or Parent/Legal Guardian Signature Date

_____ _____
Therapist Signature Date

For Office Use:

Proof of income reviewed: _____ Amount of Client Copay: _____

2750 Old Alabama Road, Suite 200
Alpharetta, GA 30022
(678) 893-5300; Fax (678) 893-5312