Bayside Counseling Center 8303
Sierra College Blvd. St. 150
Roseville, California 95661 Phone:
(916) 746-7228

www.counselor@baysideonline.com

Client Assistance Fund Application

Welcome to Bayside Counseling Center! Our mission is to enhance emotional, relational, and spiritual well-being through quality and affordable counseling. Our staff of counselors work with individuals of all ages, couples, and families who are struggling with a wide range of problems and situations. We are prepared and eager to serve you. Furthermore, we want counseling to be financially accessible. Therefore, we have established our Client Assistance Fund to assist you in accessing the services you desire.

The Client Assistance Fund is a way Bayside Counseling Center provides affordable counseling to those who may have difficulty affording the services. While every client is required to pay a fee for counseling services, the Client Assistance Fund is a subsidy that reduces the portion you are required to pay. Fees are established by considering net income, household size, and other financial resources. **The fee for your first appointment is determined by our Client Services Specialist during the intake process**.

Instructions

Please send your completed application and proof of income to **counselor@baysideonline.com. Sources for the proof of income must be current, and may include a** tax return, pay stub, or letter from your employer.

What should I consider before applying for the Client Assistance Fund?

- Do I have a savings account, investments, or other assets I could use to pay for therapy?
- Do I have a family member who can provide financial support to my therapy?
- Do I have an employer or congregation that would be willing to contribute to my therapy?

Terms and Conditions

- I will immediately notify my therapist if there is a change in my health insurance or financial status.
- My application will be reviewed at least annually, and new proof of income will be required. My fee may be adjusted if my financial circumstances change.
- I will be charged my established fee for appointments missed or cancelled without a 24-hour cancellation notice. Three incidents of this may result in a termination of the provision of assistance from the Client Assistance Fund.

Client Assistance Fund Application

Name: _____ Date: _____

Email: _____ Phone: _____

A) TOTAL NET HOUSEHOLD INCOME PER YEAR $_____

B) LIST ALL SOURCES OF INCOME (i.e., wages, disability, social security, child support).

Source of Income	Amount
1) _____	_____
2) _____	_____
3) _____	_____
4) _____	_____
5) _____	_____

C) LIST ADDITIONAL SOURCES OF FINANCIAL SUPPORT FOR THERAPY
(i.e., congregation, family, employer).

1) _____
2) _____

D) HOUSEHOLD SIZE
Total # in Household _____ # of Dependents_____

E) PLEASE EXPLAIN ANY OTHER SIGNIFICANT FINANCIAL FACTORS:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please review the information about the Client Assistance Fund attached to this application and provide your signature below, indicating I have read the terms and conditions of the Client Assistance Fund and declare that all the information I have provided in this application is true and accurate to the best of my knowledge. I understand that misrepresentations or incorrect information given to Bayside Counseling Center may affect the financial assistance I receive and result in increased fees.

_____
Client or Parent/Legal Guardian Signature

_____
Date

FOR AGENCY USE ONLY

A) CLIENT FEE: _____
B) RATIONALE FOR FEE

_____
_____
_____
_____
_____

_____
Counselor Name (please print)

_____ _____
Signature Date

_____ _____
Director Signature Date