



Coastal Connecticut Counseling

Application for Financial Assistance

Please complete the following information and attach requested documentation to determine your eligibility for financial assistance.

1) Client Name _____ Parent/ Guardian Name (if under 18) _____
Client Date of Birth _____ Client SSN (or Parent/Guardian) _____
Phone _____ Email _____
Street Address _____ Apt#/ Unit# _____
Town _____ State _____ Zip Code _____

- 2) Number of family members living in household (do not include partners): _____
- 3) Income information - please *attach one of the following to this application regarding annual income* for your household:
a) Weekly wages (include the 2 most recent pay stubs)
b) Annual salary (your most recent Federal Income Tax Return)
- 4) Are you covered under any health insurance policy, including Medicare or Medicaid? (please circle) YES NO
a) If yes, please *provide a copy of the front and back of your card* with this application.
- 5) Please *attach a listing of your monthly expenses* including, but not limited to, mortgage payment, rent, utility payments, car payment, child support, alimony
- 6) By signing below, I certify that everything I have stated on this application and any attachments are accurate:
a) I understand that any incorrect, incomplete or false information on this form could result in rejection of my application for financial assistance.
b) I give Coastal Connecticut Counseling permission to verify any and all information, including verification through a credit report.
c) I agree to repay the full amount of my financial assistance award if I receive payment of any kind, including rewards from a lawsuit, for the services covered by this application.
d) I agree to inform Coastal Connecticut Counseling of any changes in my financial status that could change my eligibility for financial assistance.
e) I understand that in connection with my application for financial assistance Coastal Connecticut Counseling may need to disclose Protected Health Information (HIPAA) about me in order to determine my eligibility. Any such disclosure will be for payment purposes as defined by the HIPAA privacy rule.
f) In applying for financial assistance and by entering into a financial assistance agreement, I agree to forfeit the use of my insurance for services.

Signature of Client (or Guardian) _____ Date _____

Printed name of person completing application _____ Relationship to client: _____

Remember to include proof of income and expenses when submitting your application

Email completed application and supporting documents to mail@coastalconnecticutcounseling.com

OR

Mail completed application and supporting documents to:
Coastal Connecticut Counseling, 2960 Post Road - Suite 3B2, Southport, CT 06890

If you have any questions please contact us at 203-307-3030