



SCHOLARSHIP APPLICATION

Family Concern Counseling makes this Scholarship Application available for those seeking counseling or other psychological services who may have financial circumstances that prohibit them from seeking our service at the normal fee. Please fill out the application and return it as soon as possible. We will contact you by phone within three (3) working days to inform you of possible scholarship funds available to reduce your fee.

Return this application to the attention of:

Director
Family Concern Counseling
2004 Valparaiso Street
Valparaiso IN 46383-3138

If you have any questions, call us at 477-5646. The Office Manager will direct your call to the appropriate Family Concern Counseling staff.

NAME: _____

SPOUSE: (if applicable) _____

ADDRESS: _____

HOME PHONE: _____

PLACE OF EMPLOYMENT: _____

Do you have insurance for psychological services? YES ___ NO ___

TOTAL NUMBER OF PERSONS IN HOUSEHOLD: _____

TOTAL HOUSEHOLD GROSS INCOME: (This includes child support, Medicaid, disability, alimony, etc.) \$ _____

If applicable: Child support paid out yearly: \$ _____ Other unusual costs: \$ _____

(PLEASE ATTACH COPIES OF TWO OF YOUR MOST RECENT PAY STUBS FOR EACH HOUSEHOLD WAGE EARNER FOR VERIFICATION. IF YOU ARE SELF-EMPLOYED, ATTACH A COPY OF LAST YEAR'S INCOME TAX RETURN.)

NOTE: If your total household income is over \$76,000, your fee will be at our established fee per session.

ADDITIONAL COMMENTS: _____

We (I) declare that we (I) have reviewed the information above; and to the best of our (my) knowledge and belief, it is true, correct, and complete.

Signed: _____ Date: _____
Client

Client No. _____