The Center
for Christian Counseling, Consultation & Training, Inc.

4868 High Crossing Blvd.
Madison, WI 53704
608.274.8294
608.274.8783 Fax

THERAPY GRANT APPLICATION

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone (_____) _____ Cell Phone (_____) _____

Employer _____ Occupation _____

Amount you propose to pay per session _____

Gross Monthly Family Income (include all wage earners) _____

Number of dependents in household _____ Balance in savings account _____

Total amount of outstanding debts (other than home mortgage or car loans) _____

Are you currently a client at The Center? Yes / No If yes, therapist name _____

If no, therapist you will be seeing _____

Do you have medical insurance coverage that will pay for sessions specifically at The Center? Yes / No
(Please contact your insurance company to verify)

If yes, amount/percentage allowed per session _____ Per year _____

Other pertinent information you would like the Review Board to know:

_____

_____

_____

_____ _____
Applicant Signature Date

Please return this completed application to the attention of your therapist at The Center. Your therapist will notify you with the results of this application.

(Office Use Only)

Grant amount approved _____ Hourly Therapy Rate _____ Therapist_____

Date _____