Kairos Counseling, LLC

Carol A. Krentz, LPC

201 South Skinker Boulevard, St. Louis, MO 63105

1715 Deer Tracks Trail, Suite 260, St. Louis, MO 63131

Phone: 314-882-0495

I. Application for Sliding Scale Fees

Completed legibly **and completely**

II. Tax Return

(Most recent Tax Return, including all Schedules

III. Documentation of ALL Income Sources

Include most recent **Paycheck Stub for ALL income-contributing family members.**
(Includes Disability, Child Support, Social Security, Rental Income, etc.)

IV. Review of Application

Prior to submission, please review application and confirm that **every** question has been answered, is legible, and that all requested documentation is attached.

Incomplete applications will NOT be processed.

To avoid unnecessary delays, **please print clearly** and provide **all** requested information..

***Please note:** Until this application is approved by Kairos Counseling, client will be responsible to pay the full service fee, payable at the time of service, for all counseling services received.

Discounts will not be given retroactively.

Client Name(s): _____

_____ Date of Application: _____

A. FINANCIALLY RESPONSIBLE PERSON

Name _____ Date of Birth _____

Relationship to Client: _____ Age _____

Marital Status (Circle One): Single Married Divorced Separated Widowed

Street Address _____

City_____ State_____ Zip _____

Home phone: ( ) _____ Work phone: ( ) _____

Cell phone: ( ) _____ E-mail address: _____

YOUR MENTAL HEALTH BENEFITS PLAN

Kairos has prepared a questionnaire to guide you through the process of gathering information about your insurance benefits. See the end of application for information.

Contact the "Customer Service" department of your insurance company and record their answers to the questions in the spaces provided.

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B. **DESCRIBE YOUR OUT-OF-NETWORK INSURANCE BENEFITS:**

Deductible Amount: $_____ Deductible met to date: $_____

Co-Pay: _____

HOUSEHOLD INCOME – Please provide the following information for yourself and all *adult* household members with any source of income.

Name Employer (Name, address, and telephone) **Gross Annual Income** _____

_____

_____

Copy of latest Tax form and most recent pay stub or copy of automatic payment

SPECIAL CIRCUMSTANCES - Please describe any other circumstances Kairos should consider: (please use reverse side to elaborate_

_____

_____

Additional financial information:
Assets or Liabilities that will be taken into consideration:
(please use additional paper if necessary).

Cash _____

(Checking, Savings, Money Market, etc**.):** _____ _____

_____

Stocks/Bonds: _____

What is the amount you think you can afford per session?_____

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Description of Assets and Liabilities

Current Fair Market Value **Current Amount Owed**

Real estate:

Personal home _____

Other:

_____

Automobiles Description:

_____-_

Automobile Description:

_____

Other personal property:

Boat(s): _____ _____

RV(s): _____ _____

Other:

Retirement Plans:

Description: _____

Description: _____ ----

Accuracy of Information / Notification of Changes

I attest to the truthfulness and accuracy of the information contained in this application.

If for any reason the information I have provided changes,:**I will contact Kairos Counseling immediately to notify them of the changes in my financial status** _____ (initials)

_____ _____

Signature of Financially Responsible Person Date

MENTAL HEALTH INSURANCE QUESTIONAIRE

A. Your Insurance Mental Health Benefits

If you have insurance benefits, we require that they be utilized before any Scholarship Funds can be awarded. Please be aware of the following:

1. You must pay for services at the time of your session(s).
2. Kairos does not process insurance claims.

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3. A receipt is provided to use in requesting reimbursement from your insurance company; receipts are sent monthly and requests for receipts must be made in writing. Please include your name, your counselor's name, and your mailing address.

B. Questionnaire

We have prepared the following questionnaire to guide you through the process of gathering information about your insurance benefits. Contact the "Customer Service" department of your insurance company and record their answers to the questions below:

1. Do I have "Behavioral Health" benefits for:
Individual Counseling? Yes No
Family Counseling? Yes No
Marital Counseling? Yes No

If ***'NO'*** to all of these items, there is no need to continue with this section.
If ***'YES'*** to any of these items, then proceed with the next question.

2. Do I have coverage for "Out of Network" providers? Yes No
If ***'NO,'*** then there is no need to continue with this section as the Wellspring Christian Counseling is not on any "Network Provider List."
If ***'YES,'*** then proceed with the next question.

3. Does my insurance company:
Require that I see a Licensed Professional Counselor (LPC)? Yes No
Allow me to see a Provisionally Licensed Professional Counselor (PLPC)?
Yes No
Allow me to see a faith-based counselor regardless of credentials? Yes No

4. How many visits am I allowed under the "Out of Network Provider Plan?" _____

5. What is my out-of-network deductible? $_____
How much has been met to date? $_____
After I meet my deductible, what is my co-pay responsibility? _____

6. Do I need to be pre-certified prior to making an appointment? Yes No
If yes, what is the pre-certification code assigned? _____

7. What is the pre-certification process? Please describe:
_____
_____
_____
_____