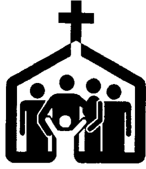
Catholic Charities



Financial Information Form

Determination of Subsidized / Amended Counseling Fee

Client Name ____ Date ___________

NOTE: If client presents a pregnancy-related need for clinical counseling the Amended Fee is set at $0.00.

1) Family Income $ __________________ (annual, monthly, bi-weekly, weekly)

Annual family income $ _______

2) Number of People in Family ________

Agreed Upon Subsidized Fee $ _______, per 50 minute session (counseling hour)

3) Describe the Extraordinary Financial Hardship, in order to justify a negotiated Amended Fee or Subsidized Co-pay

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3a) Consultation with Supervisor / Regional Director

Name of Supervisor / Regional Director ______________________________

Date of consultation ____________________

Agreed Upon Amended Fee (or Subsidized Co-pay) $ _______, per 50 minute session (counseling hour)

Signature of Client ______________________________________ Date _______

Signature of Therapist ____________________________________ Date _______