C.A.S.E. the nonprofit CENTER FOR ADOPTION SUPPORT AND EDUCATION since 1998

nurture. inspire. empower.

Confidential Request for Reduced Clinical Fees

Therapist Assigned (C.A.S.E. completes):		
Applicant Information		
Name:		
Current Address:		
City:	State:	Zip Code:
Phone:	Cell:	
Current Employer:		
Employer Address:		
Position:		
Annual Income from Employment:		
Other sources of Income:	# of Dependents/Ages:	
Co-Applicant Information		
Name:		
Current Address:		
City:	State:	Zip Code:
Phone:	Cell:	
Current Employer:		
Employer Address:		
Position:		
Annual Income from Employment:		
Other sources of Income:	# of Dependents/Ages:	
Special Needs		
Summarize any special needs/circumstances/hardships that your family is experiencing		
Agreement and Signature		
By submitting this application, I affirm that the facts set forth in it are true and complete. I understand that if my fees are reduced, any false statements, omissions, or other misrepresentations made by me on this application may result in my loss of financial aid. **Please attach a recent W-2 statement for both the applicant and co-applicant.**		
Name (printed)		
Signature	Date	
Our Policy: This request must be re-evaluated every 6 months.		
It is the policy of this organization to provide equal opportunities without regard to race, color, religion, national origin, gender, sexual preference, age, or disability. **All fee reductions must be approved by the Director of Clinical Services.**		

Approved _____ Date _____ Approved Co-pay Amount _____