Church Assistance Program Referral Form

***** Please fax this form to our office and the client will receive a call back to set up an intake appointment*****

Fax: (515) 331-9086 Telephone: (515) 331-0303

Name of Referring Church:____
Ministry leader referring the potential client:____
Date of the Referral: _________________________

Name of Client:____
Date of Birth:____
Telephone Number: ____

Why is the client being referred for mental health counseling?
____
____
____
____
____

Does the referred client have private health insurance with a Mental Health Benefit? (Circle) Yes or No

If yes, please provide the following:
Name of the Insurance Provider:____
Member ID#:____
Group ID: ____
Policy Holder's Name:____
Policy Holder's Date of Birth:____

If **no**, the church is committed to (Circle one) **PARTIALLY** or **FULLY** funding the referral's counseling for a duration of __________ sessions. If the client decides to continue with additional sessions after the determined amount of sessions, the client may either seek more financial assistance from the church or they may have to fund their own counseling. If the church elects to partially fund the referral's counseling, it is assumed that the client has been advised of their responsibility to pay a portion of the bill prior to their intake at Heartland Christian Counseling.

The signatures below indicate that this form has been reviewed between a representative of the Leadership of the Church and the potential Client being referred to for counseling at Heartland.

_________________________________ _________________________________
Signature of Church Leadership **Signature Client or Guardian (if under 18)**

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