Methodist Services for Children and Families
Community Counseling Services
Request for Two Rivers Health and Wellness Grant Assistance

Date: **Referral Source:**

Name:

Status: ☐ **New Client to Agency** ☐ **Returning Client** ☐ **Current Client**
If this client is returning to the agency or if he/she is a current client, has he/she received grant money before? ☐ **Yes (Specify:_______________________________)**
☐ **No**
For what/which services is the client seeking grant assistance?
Therapy / Psychiatric Medication Management
Is this client receiving welfare assistance (TANF, SSI, or food stamps)? ☐ **No** ☐ **Yes**
If he/she answered "yes," he/she should qualify for government-funded health insurance. Advise client to utilize these benefits when seeking services at CCS or elsewhere. He/she should contact his/her insurance to determine eligibility and identify participating providers.

Financial eligibility table for full or partial coverage

Using the TABLE below, provide a "yes" or "no" in COLUMN 4 in the corresponding row for the family size as to whether the client's income IS LESS THAN the annual or monthly amount for the family size. Specify the verification source:___________________________________

Family Unit Size	(Level 1) $5/$15 c/p 250% of FPL (Gross Annual/Monthly)	(Level 2) $20 c/p Up to 300% of FPL (Gross Annual/Monthly)	YES (indicate which level) NO (please indicate if there is additional hardship to consider)
1	Less than $32,200/$2,683	Less than $38,640/$3,220	
2	Less than $43,550/$3,629	Less than $52,260/$4,355	
3	Less than $54,900/$4,575	Less than $65,880/$5,490	
4	Less than $66,250/$5,520	Less than $79,500/$6,625	

[Add $11,350 annually or $946 monthly for each additional family member]

Does the client qualify? ☐ **Yes** ☐ **No ____**

By signing below, I acknowledge that I am responsible for paying the following copays for services received at Community Counseling.
Level 1 applicable copays
$15 – Initial Evaluation (with Therapist)/ Psychiatric services (Evaluation and Medication Management)
$5 - Therapy Sessions
Level 2 applicable copays
$20 – per service
Benefits are subject to review and may be limited based on fund availability and level of need.
In addition, my signature indicates that I understand that my case will be reviewed periodically to determine continued eligibility for grant assistance.

Applicant:_______________________________________ Date:___________________________
Name of Staff Administering Means Test:______________________________Date:__________

Updated 01/2019