Financial Assistance Application

A completed financial assistance application and proof of income must be submitted in order for us to consider you for financial assistance.

Financial assistance is available for ongoing treatment costs (e.g., therapy and/or nutrition sessions). Reimbursement for bills already paid is not available.

Financial assistance for counseling is only available at the Living Bread Counseling Center. Please sign a release for your therapist and dietitian to be able to communicate with the board of directors of Living Bread.

Please fill out the following form and submit it to your therapist/nutritionist or mail to:
Living Bread
P.O. Box 9371
Greenville, SC 29604

DATE OF APPLICATION: ____________________

1. *APPLICANT INFORMATION - PLEASE PRINT ALL INFORMATION-*					
Last Name	**First Name**	**Middle Initial**	**Date of Birth**	**Email**	
No. of Dependents (other than self& co-applicant)	**Ages of Dependents**	**Home Phone**	**Cell Phone**	**Work Phone**	
Street Address (Do Not List PO Box)	**City**	**State**	**County**	**Zip**	
Current Employer	**Street Address, City, State**	**Position**			
If you are not working, how long have you been unemployed?					

2.CO-APPLICANT (SPOUSE or PARENT/GUARDIAN or anyone else contributing to applicant's income) INFORMATION **RELATIONSHIP TO PATIENT** ☐ Spouse/Domestic Partner ☐ Parent ☐ Other __________					
Last Name	**First Name**	**Middle Initial**	**Date of Birth**		
No. of Dependents (don't include those claimed by co-applicant)	**Ages of Dependents**	**Home Phone**	**Cell Phone**	**Work Phone**	
Street Address (Do Not List PO Box)	**City**	**State**	**County**	**Zip**	
Current Employer	**Street Address, City, State**	**Position**			
If you are not working, how long have you been unemployed?					

3. INCOME INFORMATION

Monthly Income Sources	**Applicant**	**Co-Applicant**	**Combined Monthly Income**
Employment Income	$	$	$
Social Security	$	$	$
Disability	$	$	$
Unemployment	$	$	$
Other Government Aid	$	$	$
Spousal/Child Support	$	$	$
Rental Property	$	$	$
Investment Income	$	$	$
Other[s] use these spaces	$	$	$
$	$	$	
Do your parents help you financially in any way not yet listed? If yes please list amount and how the money is used.	$	$	
$	$	$	
		Total Combined Monthly Income	$

If you do not have monthly income, please explain how you take care of your monthly expenses:

4. ASSETS

Checking/Money Market/Savings Accounts: ******List all available funds.**

Type of Account:	Current Balance	Bank Name:	Current Balance
1.	$	4.	$
2.	$	5.	$
3.	$	6.	$

5. ESTIMATED MONTHLY LIVING EXPENSES (To document additional monthly living expenses use Section 6)

Monthly Expenses	Monthly Payment	Monthly Expenses	Monthly Payment
Rent/Mortgage Payment	$	Current Outstanding Bills for Medical, Dental, or Prescriptions	$
Property Taxes (if not included in mortgage payment)	$	Total Monthly Automobile Payment(s)	$
Home Owner's Insurance (if not included in mortgage payment)	$	Automobile Insurance	$
Utilities (Electricity, Gas, Water, Garbage, Recycling, etc.)	$	Automobile Gasoline	$
Food	$	Liens/ Wage Garnishments	$
Telephone (home line and cell)	$	List Other Monthly Expenses	$
Child Support	$	$	
Spousal Support/Alimony	$	$	
Child Care	$	$	
Credit Cards	$	$	
Health Insurance Premiums	$	Total Monthly Payments	$

6. ADDITIONAL INFORMATION & COMMENTS:

***7. FINANCIAL ASSISTANCE QUESTIONS*:**

1. Is the applicant applying for financial assistance with therapy at the Living Bread Counseling Center? ☐ Yes ☐ No
   Frequency: ☐ Weekly ☐ Every other week ☐ Bi-monthly ☐ Monthly
   Name of therapist: ___________________

   Does your insurance reimburse you for a percentage of out-of-network therapy costs? ☐ Yes ☐ No
   If yes, what percentage? _________
   What insurance company? _________________
2. Is the applicant applying for assistance with costs for nutritional counseling? ☐ Yes ☐ No
   If yes, please indicate frequency and cost:
   Frequency: ☐ Weekly ☐ Every other week ☐ Bi-monthly ☐ Monthly
   Name of Nutritionist: ____________________

3. Is the applicant also participating in a higher level of care, such as an Intensive Outpatient Program? ☐ Yes ☐ No
   If yes, please indicate the weekly amount you must pay (your copay): $ ________________
4. Is the applicant applying for assistance with medical monitoring by a physician? ☐ Yes ☐ No
   If yes, how frequently do you need medical follow-up appointments? _________
   Physician's Name:__________________

   Amount paid by you to physician (co-pay) per visit: $___________________________

9. SIGNATURE			
I certify that all information is valid and complete and hereby authorize Living Bread to send available finances to the services I have listed in this application and send finances to future services for which I request financial assistance.			
Applicant	**Date**	**Co-Applicant**	**Date**
______________________________		______________________________	

(revised 6/26/13)

CHECKLIST FOR ATTACHED INFORMATION:

☐ **Proof of income (e.g., pay stubs or previous tax information)**