CS Form 201.2a

Catholic Charities North Dakota Counseling Services Intake Forms and Appointment Reminder

Reminders for you as you come in for your first appointment…

Please complete ALL of this paperwork to the best of your abilities and bring it to your first appointment.

Please arrive 20 minutes before your scheduled appointment time to complete any additional paperwork.

Paying for Counseling Services:

Insurance- We accept and work with various insurance companies. You must bring your insurance card along with you to your first appointment, so we may get a copy for your file for insurance billing purposes. You will be responsible for all costs not covered by your insurance including your annual deductible, co-pays and co-insurance.

EAP- If you are using an Employee Assistance Program (EAP), please call your EAP provider prior to the appointment to get an authorization number and the number of sessions that have been approved. No payment is expected from the client when utilizing an EAP.

Self-pay - If you do not have insurance or EAP benefits, you may pay out of pocket for your therapy. Self pay fees are due and expected at the time of service.

Self Pay-Sliding Fee Scale - You may utilize the sliding fee scale. The sliding fee scale is based on household income and number of dependents. Payment for self pay sessions are due and expected at the time of service.

Self Pay-Fee Reduction - If paying the full amount for self pay or the self pay sliding fee scale amount causes a hardship to you or your family, you may apply for a reduction in the self pay amount. Extenuation financial circumstances will be consided. To receive reduced fees, you will need to fill out an application and provide proof of income (paystub, tax return). If there are additional extenuating circumstances that you would like us to consider, please provide documentation of those circumstances (medical bills, etc) and include them on your application. All applications for reduced fees must be approved by the Director of Counseling or the Executive Director.

24 hr. Cancellation and No Show Policy:

If you need to change or cancel any appointments, we have a 24 hour cancellation policy. **Please call** as soon as you know you cannot keep your appointment so that you will not be charged the $25.00 No Show Fee. We have a waiting list and need to offer these appointments to people who are waiting.

In the event of winter weather/storms: If local schools are closed due to inclement weather, our office will also be closed. These appointments will be rescheduled.

Name_____

My appointment Date: _____Time: _____

Counselor: _____

11/2017; 4/2019

CS Form 201.2b

Catholic Charities North Dakota
Counseling Services Intake Summary

Personal Information: Please complete the **entire intake form** for **each person** coming to counseling.

Date_____

Age _____

Referred by:

- ☐ Priest Name/Parish/Bulletin _____
- ☐ CCND website
- ☐ EAP _____
- ☐ Other _____

GENERAL INFORMATION:

_____
(Last Name) (First Name) (Middle Initial) (Maiden)

_____
(Address) (Apt.#) (City) (County) (State) (Zip)

_____ home cell work _____
(Phone number(s) for contact purposes) (Circle one) (Best time to call)

Gender: _____ DOB: _____ Email Address: _____

Relationship Status (single, married, separated, divorced, widow/widower, other): _____

Spouse's Name_____Were you ever married before? _____

Years of Education: _____ Degree(s): _____

Employed?: [ ] Full-Time [ ] Part-time [ ] Unemployed Occupation: _____

Student?: [ ] Full-time [ ] Part-time Other: _____

Medical History

Physician(s): _____ _____ Clinic: _____

Approximate date of last medical appointment: _____ Results: _____

Medications taken regularly: _____

Significant medical problems that apply to you or to members of your family:
_____
_____
_____

Are you currently in counseling elsewhere? Yes No
What other counseling have you had in the past (When, therapist/clinic, for what issues):
_____
_____
_____

Revised 11/2017

CS Form 201.2b

*Client Name*_____

FAMILY INFORMATION:

Children *(Please include miscarriages, abortions, placed a child for adoption, deceased and stillborn)*:

Name	D.O.B.	School/Occupation

Siblings *(Please include deceased and **yourself** in the birth order)*:

Name	D.O.B.	City & State

Parents *(Please include biological and non-biological)*:

Name	D.O.B.	Status	City & State

REASON FOR VISIT:

What are the problems that bring you here?

_____
_____
_____
_____

In your opinion, what is causing the problem?

_____
_____
_____
_____

Your goals for counseling:

_____
_____
_____
_____

Please check any concerns that you presently have for yourself about the following:

☐ Suicidal thoughts	☐ Self-Injury	☐ Alcohol/chemical use/abuse
☐ Victim of physical abuse	☐ Victim of sexual abuse	☐ Victim of emotional abuse
☐ Addictive behaviors	☐ Miscarriage	☐ Abortion
☐ Anxiety	☐ Anger	☐ Relationship problem
☐ Depression	☐ Annulment	☐ Intent to hurt another person

Other (please specify): _____

Please complete this section if someone other than the client is completing this form.

Name _____**Relationship to client** _____

Address _____

Phone numbers _____

Revised 11/2017

CS Form 201.2b

CCND/CS Emergency Contact Information

Client Name_____

In case of Emergency, who do you want us to contact?

Primary Emergency Contact:

Name _____

Phone Number _____ Relationship _____

Address _____

If we are unable to contact the Primary Emergency Contact, we will contact:

Name _____

Phone Number _____ Relationship _____

Address _____

Catholic Charities North Dakota
Forever Grateful Since 1923

CCND/CS Appointment Reminder Preference

As a courtesy, we will give you a reminder contact one business day before your therapy appointment. Which do you prefer?

[ ] Phone call at # _____
[ ] Can leave message [ ] Please don't leave message

[ ] E-Mail at _____

[ ] No reminder necessary

Client Name_____

CS Form 201.2c

DATA COLLECTION FORM

This optional information is used for statistical purposes. We appreciate you taking the time to complete this form. We must report on the client population that we serve.

Client Name:_____ **Date:** _____
Address:_____**City:** _____ **County:** _____ **State:** _____

Gender: _____
Age: ___0-10 ___11-20 ___21-30 ___31-40 ___41-50 ___51-60 ___61-70 ___71-80 ___ 81+

Marital Status: ___ Single ___ Separated ___Engaged ___ Divorced ___Married____Widowed

Household Structure: ___Traditional ____ Single Parent____ Step-Family____Live Alone ____ Cohabiting ____Live w/Roommate ____ Other (Please Specify) _____

Household Income: __ 0-$9,999 __ $10,000-$14,999 __$15,000-$19,999
__$20,000-$29,999 __ $30,000-$39,999 __$40,000-$59,999
__$60,000-$79,999 __ $80,000-$99,999 __$100,000+

Occupation:
__ Student __ Homemaker __ Retail/Sales __ Trade/Technical ___ Food Service/Accommodation
__ Education __ Professional ___Retired __ Transportation __ Religious __ Unemployed __ Daycare
__ Administrative/Clerical __ Other (Please Specify) _____

Financial Responsibility: __ Self (Private Pay) __ Insurance__ EAP__Church__ Parents
Other (Please Specify)_____

Do you attend a church: ___ Yes ___ No **Church Name:**_____

Denomination Attending:
___ Catholic ___Lutheran Brethren ___ Lutheran ___ Evangelical Free ___ Baptist ___ Methodist
___ Assembly of God ___Pentecostal ___ Nazarene ___ Presbyterian ___ Non-denominational
___ Other (Please Specify) _____

Referral Source:
__ Church/Clergy __ Physician __ Professional __ Former Client __ Friend __ Relative __ Internet Search
__ Radio __Yellow Pages __ Court ___ Other (Please Specify) _____

Type of Counseling: ___ Individual ___ Couple/Marital ___ Family ___ Pre-Marital ___ Group/Class

Race/Ethnicity: ___White (Caucasian) ___Black (African-American) ___ American Indian/Native Alaskan
___ Asian American___Middle Eastern ___Hispanic/Latino ___Prefer not to respond ___ Unknown
___Other _____
Language spoken at home: _____**Do you require an interpreter?**_____yes _____no
Refugee: _____yes _____no

CS Form 201.2d

Catholic Charities North Dakota Counseling Services
Information and Consent Form

Thank you for choosing Catholic Charities North Dakota Counseling Services. We hope that your experience with us is useful in addressing your concerns. This form is designed to assist you in understanding important aspects of our counseling process.

The Purpose of Counseling:
Through a professional relationship with your counselor, you will be encouraged to discover your own strengths and learn helpful resources that can assist you in overcoming your challenges and struggles. Counseling often involves hard work. It requires your time, your active cooperation and your commitment.

Each of Catholic Charities counselors have a Master's Degree in Social Work, Counseling, or Marriage and Family Therapy. They are licensed in the state of North Dakota and stay current in their profession by regularly staying current with best practice in the field. Our counselors adhere to the ethical standards set by their profession. Our counselors are committed to providing competent and professional services to you.

Fee Policy:
For self-paying clients, payment is expected at the beginning of each session. If you have a diagnosable mental health condition and are covered by health insurance, Catholic Charities will bill the insurance company directly. Marriage and relationship counseling is not covered by most insurance companies, but we always suggested that you call your insurance company to be certain. **It is the client's responsibility to contact their insurance company to know the extent of their coverage.** We also accept Employee Assistance Programs (EAPs). Many employers have available EAP services for their employees. Ask your employer if you are unsure if your place of employment has EAP services available for you.

Cancellation and No Show Policy: It is important that you arrive promptly for appointments and we ask you to contact our office if you will be late or need to reschedule your appointment. If it is necessary for you to cancel an appointment, a 24 hour notice must be given. We can then offer that time slot to another individual who is on our waiting list and in need of services. An appointment that is missed without 24 hrs. Notice is considered a No Show. If this occurs, you will be billed a No Show Fee. The standard No Show Fee is $25.00. If two or more No Shows occur, you will not be able to reschedule an appointment without approval from the counselor. You may have to discuss these issues with your counselor to make plans to resolve this issue, as this can demonstrate that you are not currently ready to commit to therapy. It is our policy to allow only one appointment to be scheduled at a time.

Confidentiality: Your confidentiality will be protected with great care. However, counselors are Mandated Reporters and are required to report situations of suspected abuse or neglect of a child or vulnerable adult, potential suicidal behavior or threats towards others. In addition, in certain unusual situations, the court may subpoena counseling records.

After Hours Emergencies:
If you are in a crisis and need immediate assistance:

- **Call 911, call law enforcement, or visit your local Emergency Room,**
- **Call your primary care physician,**
- **Call a suicide hotline 1-800-273-TALK (8255).**

CS Form 201.2d

Terminating Treatment: You have the right to terminate or take a break from your treatment at any time without permission or agreement. Clinicians will discuss termination and aftercare plans in your last session. If you do decide to exercise this option, we encourage you to talk with your therapist prior to terminating your treatment so that you can bring sufficient closure to your work together. In your final session, you can discuss your progress thus far and explore ways in which you can continue to utilize the skills and knowledge that you have gained throughout your therapy. You can also discuss any referrals that you may require at that time.

Client Signature _____ Date _____
Parent/Guardian Signature _____ Date _____

PR1.0b, ADM19.0a, CS202a

Catholic Charities North Dakota Acknowledgement of Receipt of Privacy Notice, Client Rights and Responsibilities Brochure, and the Electronic Communications with Clients or Electronic Communications Containing Protected Health Information Policy

Client Name: _____ File Number: _____

By signing this form, you acknowledge that Catholic Charities North Dakota has given you a copy of its Privacy Notice, which explains how your health information will be handled in various situations. By signing this form, you acknowledge that Catholic Charities North Dakota has given you a copy of its CLIENT RIGHTS AND RESPONSBILITIES BROCHURE, which explains your rights and responsibilities as a client. By signing this form, you acknowledge that Catholic Charities North Dakota has given you a copy of its Electronic Communications with Clients or Electronic Communications Containing Protected Health Information Policy, which explains how we handle various forms of electronic communication. We must try to have you sign this form on your first date of service or upon assessment for eligibility for services with us. If your first date of service with us was due to an emergency, we must try to give you this information and get your signature acknowledging receipt of this information as soon as we can after the emergency.

Check all that are true:

[ ] I have received Catholic Charities North Dakota's Privacy Notice, Client Rights and Responsibilities Brochure, and the Electronic Communications with Clients or Electronic Communications Containing PHI Policy.

[ ] Catholic Charities North Dakota has given me the chance to discuss my concerns and questions about any of the provided information.

_____ _____
Client's Signature Date

_____ _____
Parent/Guardian's Signature Date

Catholic Charities North Dakota's staff should complete if Acknowledgement Form is not signed:

Does client have a copy of the this information? [ ] Yes [ ] No

Please explain why the client was unable to sign an acknowledgement form and Catholic Charities North Dakota's efforts in trying to obtain the client's signature:

_____
_____

_____
CCND staff signature Date

11/2017

CS Form 201.2d

Catholic Charities North Dakota Counseling Services
Consent for Minors Form

Consent for Minors: I have the legal right as parent/guardian to grant Catholic Charities North Dakota permission to provide counseling services for _____ (minor). I understand that by giving my permission to see the above minor, I have a right to consultation regarding progress and agree to cooperate with the therapist to facilitate services for this child. Counseling is for the benefit of the child/children. Special sensitivity may be required in releasing information to the parent/guardian due to the therapeutic relationship between the child and therapist. I will accept the therapist's professional judgment in regard to releasing or sharing information obtained during the course of counseling with this minor.

Signatures: The signatures below indicate that the client and parent/guardian understand the information contained on this form and has had an opportunity to clarify.

Client Signature: _____ Date _____

Parent/Guardian Signature: _____ Date _____

CS202

CATHOLIC CHARITIES NORTH DAKOTA

Electronic Communications with Clients or Containing Protected Health Information Policy

In order to inform clients of the inherent risks involved with any electronic communication used as a means to communicate during their treatment, CCND/CS has prepared the following policy. The use of various types of electronic communications is common in our society, and many individuals believe this is the preferred method of communication with others, whether their relationships are social or professional. Many of these common modes of communication, however, put your privacy at risk. Consequently, this policy addresses the security and confidentiality of client treatment.

Phone Calls

Regularly, CCND/CS uses a landline phone physically located at the CCND/CS service location. This is the preferred method of communication used by CCND/CS staff. Clinicians should not give clients their personal cell phone number.

Email Communications

CCND/CS will use email communication only with client permission. If Protected Health Information (PHI) needs to be emailed to a client or received from a client, the document may be password protected to safeguard client privacy. If the client agrees to communicate via email and would like to password protect the information, the document password would be established and instructions for password protecting documents would be shared with you.

Directions to password protect a word document:

1. Open the file you want to password protect
2. Click File on the top left menu, then Save As
3. Choose the same location or pick a different one if you want
4. On the bottom right, click Tools, then General Options
5. You may enter a password to open and/or modify
6. You may also click the box that says "Read Only Recommended"; if the person you send this to tries to make changes, they will have to save the file with a different name
7. Then click OK at the bottom and Save on the next screen

Text Messaging

Because text messaging is a very unsecure and impersonal mode of communication, we only use text message to do client appointment reminders with the client's permission. CCND/CS will only use "computer to text" applications to send the appointment reminders. CCND does not respond to text messages from anyone in treatment with a CCND/CS clinician. Clients should not text message CCND unless they have made other arrangements.

CCND Website

CCND has a website that clients are free to access. CCND uses it for professional reasons and to provide information to others about our organization and our mission. Clients are welcome to access and review the information that CCND has on our website and, if the client has questions about it, they should discuss them during their therapy sessions.

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ Age: ____ Sex: ❑ Male ❑ Female Date:_____

If this questionnaire is completed by an informant, **what is your relationship with the individual? _____**
In a typical week, approximately how much time do you spend with the individual? _____ hours/week

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

Brief Trauma Questionnaire

The following questions ask about events that may be extraordinarily stressful or disturbing for almost everyone. Please circle "Yes" or "No" to report what has happened to you.

If you answer "Yes" for an event, please answer any additional questions that are listed on the right side of the page to report: (1) whether you thought your life was in danger or you might be seriously injured; and (2) whether you were seriously injured.

If you answer "No" for an event, go on to the next event.

Event	Has this ever happened to you?	If the event happened, did you think your life was in danger or you might be seriously injured?	If the event happened, were you seriously injured?
1. Have you ever served in a war zone, or have you ever served in a noncombat job that exposed you to war-related casualties (for example, as a medic or on graves registration duty?)	No Yes	No Yes	No Yes
2. Have you ever been in a serious car accident, or a serious accident at work or somewhere else?	No Yes	No Yes	No Yes
3. Have you ever been in a major natural or technological disaster, such as a fire, tornado, hurricane, flood, earthquake, or chemical spill?	No Yes	No Yes	No Yes
4. Have you ever had a life-threatening illness such as cancer, a heart attack, leukemia, AIDS, multiple sclerosis, etc.?	No Yes	No Yes	N/A
5. Before age 18, were you ever physically punished or beaten by a parent, caretaker, or teacher so that: you were very frightened; or you thought you would be injured; or you received bruises, cuts, welts, lumps or other injuries?	No Yes	No Yes	No Yes
6. Not including any punishments or beatings you already reported in Question 5, have you ever been attacked, beaten, or mugged by anyone, including friends, family members or strangers?	No Yes	No Yes	No Yes
7. Has anyone ever made or pressured you into having some type of unwanted sexual contact? Note: By sexual contact we mean any contact between someone else and your private parts or between you and some else's private parts	No Yes	No Yes	No Yes
8. Have you ever been in any other situation in which you were seriously injured, or have you ever been in any other situation in which you feared you might be seriously injured or killed?	No Yes	N/A	No Yes
9. Has a close family member or friend died violently, for example, in a serious car crash, mugging, or attack?	No Yes	N/A	No Yes
10. Have you ever witnessed a situation in which someone was seriously injured or killed, or have you ever witnessed a situation in which you feared someone would be seriously injured or killed? Note: Do not answer "yes" for any event you already reported in Questions 1-9	No Yes	N/A	N/A

CS Form 304.5a

Catholic Charities North Dakota Counseling Services
Counseling Insurance Claim Information
ALL INFORMATION MUST BE COMPLETED TO SUBMIT A CLAIM TO YOUR INSURANCE COMPANY

Client Name_____

INSURED'S INFORMATION
Primary Insurance Company Name:
Insured's I.D. Number: Group I.D. Number:
Policyholder's Name:
Policyholder's Gender:_____Male_____Female
Relationship to Policyholder: [ ] Self [ ] Spouse [ ] Child [ ] Other:
Policyholder's Address:
Policyholder's Phone Number: Policyholder's Date of Birth:
Policyholder's Employer's Name:

Secondary Insurance Company Name (if applicable):
Policyholder's I.D. Number: Group I.D. Number:
Policyholder's Name:
Policyholder's Gender:_____Male_____Female
Relationship to Policyholder: [ ] Self [ ] Spouse [ ] Child [ ] Other:
Policyholder's Address:
Policyholder's Phone Number: Policyholder's Date of Birth:
Policyholder's Employer's Name:

I authorize the release of any medical or other information necessary to process this claim. I also authorize payment of medical benefits directly to Catholic Charities North Dakota for Counseling Services.

Signature: _____ Date: _____

CS Form 304.5b

Catholic Charities North Dakota Counseling Services Fees

$200 for an Initial Individual or Couples Assessment (usually 1 ½ hours) by LPCC, LCSW, or LMSW

$150 for each subsequent Individual or Couples session (usually 1 hour) by LPCC, LCSW, or LMSW

$150 for Family sessions with client present (usually 1 hour) by LPCC, LCSW, or LMSW

Rates for PhD are as follows:
$450 for an Initial assessment for (usually 1 ½ hours)
$350 for individual or couples session (usually 1 hour)
$575 for1st hour of testing
$ 325 for hour for additional testing services

Health Insurance

For individuals who have a diagnosable mental health condition we can bill your insurance company, in which case we require an insurance information form completed and a copy of your insurance card(s). **The client is responsible to contact their insurance company to know the extent of their coverage and pay for the portion that your insurance company does not pay. This is including deductibles, co-insurance and co-pay amounts.**

Employee Assistance Program (EAP)

Counselors at Catholic Charities North Dakota are credentialed with a number of Employee Assistance Programs (EAP). If your employer offers these benefits to its employees, contact your employer's EAP Company to arrange for sessions at Catholic Charities North Dakota. Most EAPs will give you an authorization number and the number of sessions that they have authorized for you.

Self Pay

If you do not have insurance, EAP benefits, or your benefits do not cover the cost of your sessions, you may pay the cost out of pocket for your therapy. Self Pay Fees are due at the time of service

Self Pay-Sliding Fee Scale

This cost is based on your monthly or annual household income and the number of family members in your home. All self pay fees are due at the time of service.

Self Pay-Reduced Fees

If paying the full amount for self pay or the self pay sliding fee scale amount causes a hardship for you or your family, you may apply for a reduction in the self pay amount. Extenuating financial circumstances will be considered. To receive reduced fees, you will need to fill out an application and provide proof of income (paystub, income tax return). If there are additional extenuating circumstances that you would like us to consider, please provide documentation of those circumstances (medical bills, etc.) and include them on your application. All applications for reduced fee must be approved by the Director of Counseling or the Executive Director.

Payment

Catholic Charities North Dakota accepts Visa, MasterCard, and Discovery credit cards. We also accept many flex cards as well. You can pay your bill with a check or cash. You can also pay your bill on line at catholiccharitiesnd.org.

CS Form 304.5b

FEE AGREEMENT

Client Name_____ **File#:**_____

My fee agreement is:

___ Primary Insurance Name of Insurance Company: _____

___ Secondary Insurance Name of Insurance Company: _____

The client will be responsible to pay all remaining costs after insurance has paid.
This includes annual deductible, co-pays and co-insurance.

___ EAP: Name: _____ Authorization ID Number #: _____
Number of sessions Authorized: _____

___ Self-Pay: $200.00 for Initial session and $150.00 per one hour session thereafter (LPCC, LCSW, LMSW)
$450.00 for Initial assessment and $350.00 per one hour session thereafter.(PhD)
$575.00 for initial testing hour and $325 per hour for each additional (PhD)

___ Self-Pay Sliding Fee Scale: $_____per session
Monthly/Yearly Household Gross Income from all sources $_____
Number of People in your Household _____

Self-pay Sliding Fee Scale-Cost per 1 Hour Session

Family Income		Number of People in your Household					
Yearly Gross	**Monthly Gross**	**1**	**2**	**3**	**4**	**5**	**6**
Below 20,147	1,679	20	20	15	15	10	10
Below 27,214	2,268	30	30	25	25	20	20
Below 34,281	2,857	40	40	35	35	30	30
Below 41,348	3,446	50	50	45	45	40	40
Below 48,415	4,035	60	60	55	55	50	50
Below 55,482	4,624	70	70	65	65	60	60
Below 62,549	5,213	80	80	75	75	70	70
Below 69,616	5,802	90	90	85	85	80	80
Below 76,683	6,391	100	100	95	95	90	90
Above 76,683	6,391	Does not qualify					

*****Income above $76,683 does not qualify for the self pay sliding fee scale*****

___ I have completed an application to reduce my self-pay fees. Reduced Fee amount is: $_____.
(office use only)

___Other (i.e.; Parish, Diocese) _____

I understand that by signing this fee agreement I am making the commitment to pay for my sessions in the manner agreed upon. I also agree that it is my responsibility to inform Catholic Charities if my financial situation changes and I need to initiate a new fee agreement. I understand that I may be charged a No Show Fee for any missed appointments and appointments that are not cancelled at least twenty four (24) hours in advance. The standard No Show Fee is $25.00 regardless of your fee agreement amount.

Client Signature_____ Date _____

Client Signature _____Date _____

Parent/Guardian Signature _____Date _____

CCND Representative Signature _____Date _____

Revised 11/20/2017; 04/01/2019; 03/01/2020

CS Form 304.5c

Catholic Charities North Dakota Counseling Services

Application to reduce my Self-Pay Sliding Fee Scale amount

Name_____
Date of Birth_____
Employer_____
Monthly/ Yearly Household Gross Income from all sources_____
Number of People in your Household _____

You may be asked to provide proof of income and any other documentation you would like us to consider.

Extenuating circumstances you would like CCND to consider when determining a reduced self pay fee for counseling services:

_____
_____
_____
_____
_____

I certify under penalty of law that the information I have provided above is true and accurate to the best of my knowledge.

Client Signature_____ Date _____

Client Signature _____Date _____

Parent/Guardian Signature _____Date _____

For office use only.

Current Self-Pay amount is $_____ per session.

Reduced fee per session after considering extenuating circumstances as listed on the application $_____

Reduced fee application approved by _____ Date _____