Psychology For ALL

Client Application Packet

Psychology For All | PO Box 49556, Charlotte, NC 28277
www.psychologyforall.org

APPLICATION FOR ENROLLMENT

(Please fill out completely and use the back of the form as necessary.)

Today's date: ____

Full Name: ____

Age & Date of Birth: ____

Address: ____

City: ______________________________ State: ____________ Zip: ____________

Do we have permission to call and leave message?

Home Phone: ______________________ Yes: ________ No: ________

Work Phone: ______________________ Yes: ________ No: ________

Cell Phone: ______________________ Yes: ________ No: ________

Which phone number do you prefer we use: Home: ______ Work: ______ Cell: ______

Do we have permission to email you? Yes ______ No ______ If yes, please provide email address:

______________________________@__________________.__________

Please list monthly income from each of the following:

Salary/Wages: $______________________
Social/Supplemental Security: $______________________
Retirement/Pension: $______________________
Unemployment Benefits: $______________________
Disability: $______________________
Child Support/Alimony/TANF: $______________________
Other (explain: ______________): $__________
Total Gross Monthly Income: $______________________

Annual Income Range (please check):
___ Under $10,000
___ $10,000 - $15,000
___ $15,000 - $20,000
___ $20,000 - $25,000
___ $25,000 - $30,000
___ Over $30,000

PLEASE PROVIDE PROOF OF ALL INCOME (including your last 3 paystubs)

Number of people in your household:_________

Number of dependents under your care: ________

Gender Preference for Provider: Male: ________ Female: ________

Language Preference: English: ________ Spanish: ________

If student, school currently attending: ____

By whom were you referred? ____

May we have permission to thank the referral source (without identifying you by name)?

Yes: __________ No: _________ Please initial: ________

The following questions will help us provide appropriate referral(s):

What are you experiencing/ or what has happened that has caused you to seek counseling?

____

____

Have you received previous counseling: Yes: _____________ No: _________ If yes, please explain:

____

____

Please indicate any geographic preference within Mecklenburg County? ________________________

____

I hereby certify that the information provided herein is true and correct.

Signed: ____ Date: ________________

Please complete this form and return it to Psychology For All.

P.O. Box 49556

Charlotte, NC 28277

info@psychologyforall.org

Psychology for All (PFA)
Client Participation Agreement

This Client Participation Agreement (this "Agreement") is made on ___________________, 20____, between Psychology for All, Inc. ("PFA") and the individual named on the signature page ("Client" or "you").

1. **Services.** PFA has established a network of licensed mental health practitioners (the "Network") who have agreed to provide limited professional mental health care services to individuals who apply to PFA for assistance and who are approved to receive assistance from PFA. As a client of PFA, you are eligible (a) to receive a referral to a licensed mental health practitioner (each, a "Provider") in the Network and (b) to receive up to 8 45-60 minute counseling sessions to be conducted within 6 months of your first session with a Provider at no charge and, if recommended by a Provider and approved by PFA, receive an additional 8 45-60 minute counseling sessions to be conducted within 12 months of your first session with the Provider at $20 per session to be paid to the Provider (the "Services"), subject to the terms and conditions set forth in this Agreement.

2. **Client Rights and Responsibilities**.

As a client of PFA, you are entitled to:

- Receive the Services, unless earlier terminated in accordance herewith.
- Information about any procedures, methods of counseling, techniques and possible duration of therapy.
- Participate in treatment decisions during his or her care.
- Be treated at all times with dignity and respect.
- End counseling at any time without any moral, legal or financial obligations other than those already accrued.

You agree to:

- Give updated information to PFA about your eligibility to participate in PFA's programs.
- Give information the applicable Provider needs to give appropriate care.
- Follow the applicable Provider's recommended plans and instructions for care.
- Participate in the treatment process through a focus on problems and the development of mutually agreed upon treatment plans and goals.
- Keep your scheduled appointment.
- Comply with other guidelines established by PFA and/or the Provider.

If you do not comply with any of the above requirements, or if you do not satisfy PFA's eligibility criteria at any time (which are attached and may be updated by PFA in its sole discretion from time to time), you will become ineligible for the Services and PFA may terminate this Agreement immediately.

3. **Appointment Scheduling, Cancellation and No-Show Policies**. All appointments must be scheduled between you and the applicable Provider. If you cannot keep your scheduled appointment, you must give the applicable Provider at least 24 hours notice. The applicable Provider may require a longer notice period. Without this notice, you will be treated as having used one counseling session. If you miss two appointments without giving the applicable Provider at least 24 hours notice, you will become ineligible for the Services and PFA may terminate this Agreement immediately.

4. **Emergencies**. If you have a clinical emergency after the applicable Provider's regular business hours, call 911 or go to your nearest hospital emergency waiting room.

5. **Termination of Services and Agreement; Transfer of Records**. You may terminate the Services for any reason. Upon termination or completion of the Services, this Agreement will terminate automatically. Sections 8 and 9 shall survive any termination of this Agreement. After termination, if you ask, PFA will make every effort to give you a referral to another

provider. You may request that the applicable Provider transfer your records to a new provider by signing an authorization to release your medical information.

6. **Privacy and Confidentiality**. Each Provider is subject to federal and state laws protecting medical and mental health records. The applicable Provider will give you with a notice of privacy practices and information explaining how your information is collected, how it is protected and how it may be shared. PFA will not receive any information about your services other than (a) confirmation that you have attended counseling sessions in order to process payment for those sessions to the applicable Provider, and (b) as authorized by you pursuant to a release of medical information.

7. **Fees.**

Counseling (45 – 60 Min.) (first 8 sessions):	$0.00 per session
Counseling (45 – 60 Min.) (next 8 sessions, if approved):	$20.00 per session (to be paid by you directly to the applicable Provider)

8. **Indemnity; Role of PFA**. PFA's role under this Agreement is to maintain a network of mental health practitioners and to reimburse the applicable Provider for Services provided under this Agreement. All providers in PFA's network are independent contractors. You agree to indemnify and hold harmless PFA, its employees, officers, trustees, affiliates, agents and representatives from and against any losses, costs, damages, and expenses (including, without limitation, reasonable attorneys' fees and costs) that arise or relate in any way to the Services or this Agreement.

9. **Arbitration, Governing Law**. Any controversy or claim arising out of or relating to this Agreement, or the breach thereof, shall be settled by arbitration administered by the American Arbitration Association in accordance with its Commercial Arbitration Rules. The laws of the State of North Carolina shall be applied in any arbitration proceedings, without regard to principles of conflict of laws. The arbitration hearing shall take place in Mecklenburg County, North Carolina before a single arbitrator. Judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction thereof.

10. **Discrimination**. PFA does not discriminate based upon age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, or language.

11. **Client Agreement**. You have read and you understand this Agreement. You agree to the terms and conditions set forth herein. You acknowledge that you may request a copy of this Agreement at no charge.

Client Name: ____

Signature: ____

Date: ____

Psychology For All

By: ____

Its: ____

Date: ____

Eligibility Criteria

- Must be over the age of 18.
- Must be uninsured and ineligible for Medicare, Medicaid, or other state or federal health insurance.
- Must be at or below 175% of the Federal Poverty Guidelines (see https://aspe.hhs.gov/2020-poverty-guidelines), as updated from time to time. Guidelines for 2020 are as follows:

	100%	**175%**
Family of 1:	$12,760 a year ($1,063.00/month)	$22,330 a year ($1,861.00/month)
Family of 2:	$17,240 a year ($1,437.00/month)	$30,170 a year ($2,514.00/month)
Family of 3:	$21,720 a year ($1,810.00/month)	$38,010 a year ($3,168.00/month)
Family of 4:	$26,200 a year ($2,183.00/month)	$45,850 a year ($3,821.00/month)
Family of 5:	$30,680 a year ($2,557.00/month)	$53,690 a year ($4,474.00/month)
Family of 6:	$35,160 a year ($2,930.00/month)	$61,530 a year ($5,128.00/month)
Family of 7:	$39,640 a year ($3,303.00/month)	$69,370 a year ($5,781.00/month)
Family of 8:	$44,120 a year ($3,677.00/month)	$77,210 a year ($6,434.00/month)

- Must give proof of household income (tax return, Form W-2, paystub, proof of unemployment).
- Must be able to see a mental health provider in Mecklenburg County, North Carolina.