CDCW

COUNSELING AND DIAGNOSTIC CENTER OF WOODFIELD, LTD.

Financial Hardship Form

This form must be completed due to the fact you have requested financial accommodations from the Counseling and Diagnostic Center of Woodfield, Ltd. (CDCW) to assist you in participating in your behavioral health treatment. Due to ethical, legal and contractual issues, our practice must have documentation of your financial need in order to be able to provide such an accommodation. The therapist must agree to these accommodations. Accommodations cannot always be provided, as much as we would like to be able to do so. In addition, please note that all accommodations are time-limited, as we need to reevaluate the continued need for adjustments periodically (e.g., you may be unemployed and the accommodation will be discontinued when employment is secured). Please answer the following questions to the best of your ability. Provide supportive documentation when possible.

Number of dependents: _____ Number of incomes in family: _____

Income #1: $ _____ (*Circle One:* weekly, monthly, yearly)

Income #2: $ _____ (*Circle One:* weekly, monthly, yearly)

Total Family Income: $ _____ (*Circle One:* weekly, monthly, yearly)

How long is it expected the primary source of income will be unemployed and/or incapacitated?

_____

Please provide an explanation: _____

Please estimate your monthly expenses: $ _____

Please provide any other information you find pertinent to your request for financial accommodations:

_____

Clinic Use Only

Time frame/Date of expiration for Financial Adjustment: _____

Specifics of Adjustment: _____

My signature below verifies that the previous answers are true, to the best of my knowledge. I understand that the financial information I have provided is strictly for the purpose of determining financial accommodations from the CDCW, and will not be used for improper purposes or unnecessarily disclosed. I further understand that the signatures also constitute a binding financial arrangement between the Responsible Party and the CDCW and that the CDCW may cancel the continuation of this financial adjustment at any time, with notice, for any reason including, but not limited to, if my answers provided are found to be incorrect, and/or if the Client/Client's family's financial situation improves as determined by the discretion of CDCW.

_____ _____ _____ _____

Signature of Responsible Party *Date* *Clinician Signature* *Date*

_____ _____

David R. Jezl, Psy.D., Clinical/Executive Director *Date*