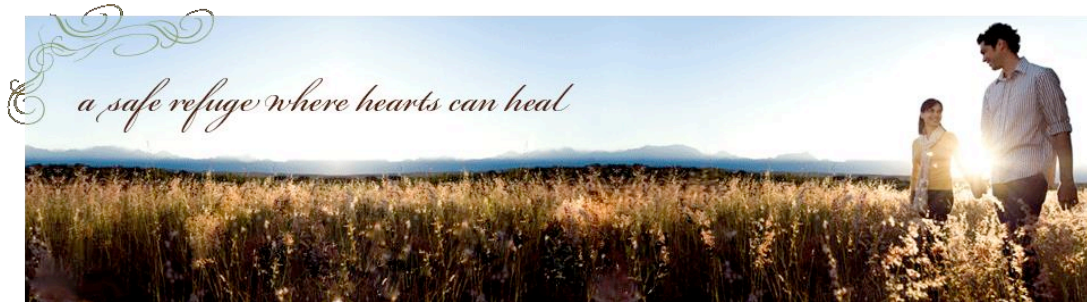


BAYSIDE COUNSELING MINISTRY



It is our desire to assist you with counseling that is both biblical and appropriate to your level of need. All counseling is provided by individuals who have a personal relationship with Jesus Christ.

APPLICATION INSTRUCTIONS:

- 1) Fill out the application by hand or electronically.
- 2) Return your application via the following options: (PLEASE NOTE: options 1 & 2 have quickest response)
 - Fill out interactive form electronically, save, then email it to: care@baysideonline.com
 - Print, fill out manually, scan, then email to: care@baysideonline.com
 - Print, fill out, then drop off at the Granite Bay Church Office: 8207 Sierra College Blvd. (M-F, 9am-5pm)
 - Print, fill out, then mail to: Bayside Church Counseling Ministry, PO Box 2336, Granite Bay, CA 95746
- 3) Allow 5-10 working days for case assignment to one of our counselors. They will call you to set up the appointment.

FEE STRUCTURE:

- Clinical Counseling Reduced Fee: \$80.00, per 1 hour session
- Low-Income/Sliding Scale Fee*: \$35.00 - \$80.00, per 1 hour session

*Our low-income clients who are unable to afford the full amount may pay a portion of the fee based on the Sliding Scale below as long as they provide documentation of income.

Your Sliding Scale fee will be determined by:

- Evaluating your household gross monthly income and the number of people this income supports. (1 person, 2 people, etc.)
- Those applying for the low-income sliding scale fee **MUST BRING DOCUMENTATION** of their monthly income to their first scheduled counseling appointment: **2 pay stubs for each working spouse, or a copy of your Federal Tax Return.**
- Those **WITHOUT** documentation will be charged the **regular fee of \$80.00**

SLIDING SCALE

| Gross monthly income (before deductions) | 1 Person household | 2 Person household | 3 Person household | 4 Person household | 5 Person household |
|--|--------------------|--------------------|--------------------|--------------------|--------------------|
| Under \$3,000 | \$45 | \$40 | \$35 | \$35 | \$35 |
| \$3,000 – 4,000 | \$50 | \$45 | \$40 | \$35 | \$35 |
| \$4,000 – 5,000 | \$60 | \$50 | \$50 | \$50 | \$50 |
| \$5,000 – 6,500 | \$80 | \$80 | \$80 | \$80 | \$80 |

BAYSIDE COUNSELING APPLICATION

Have you been referred to a particular Counselor? Yes No

Name of Counselor you were referred to: _____

Who referred you? _____

This application is for: Marriage and/or Couple's counseling Individual Female Individual Male
 Parent & Child Grief

NAME _____ Date of Birth _____

Spouse _____ Date of Birth _____

Child _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Home #: _____ Cell #: _____ Email _____

MARITAL STATUS

Single _____ Living together for _____ years Married for _____ years Legally Separated _____

Divorced for _____ years, after _____ years of marriage. Widowed for _____ years, after _____ years of marriage

YOUR EMPLOYER _____

Occupation _____ Work # _____

Spouse's Employer _____

EMERGENCY CONTACT: Name _____ Contact # _____

Relationship: _____

CHURCH INFORMATION

Do you attend Bayside Church of Granite Bay? Yes No If yes, how long? _____

Do you attend Bayside Church of Midtown? Yes No If yes, how long? _____

Attendance Weekly _____ Monthly _____ Occasionally _____

Attend a Small group? Yes No Name of group/leader: _____

Are you attending another church? Name: _____

If yes, did you call and seek counseling from your home church first? Yes No

Please explain: _____

COUNSELING HISTORY

Have you ever consulted a counselor, psychotherapist or psychiatrist before? Yes No

| Name of therapist | Dates seen (from when to when) | Reason |
|-------------------|--------------------------------|--------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

MEDICAL HISTORY

Name of Primary Care Physician: _____ Contact #: _____

Have you taken, or are you now taking, any prescription medications for mental health issues? Yes No

What prescriptions? _____

For how long? _____

Prescribed by whom and for what condition(s)?

Have you or other family members had a previous psychiatric hospitalization? Yes No

Who? _____ When? _____

For what condition? _____

Please give a brief summary of the **specific reason** you are seeking counseling at this time. Be assured this information is confidential and will be used only for the purpose of assigning you to the appropriate counselor.

Appointment Availability: Please **Check** the days and time periods **YOU ARE ABLE** to attend. Keep in mind the heaviest demand for appointments is after 4:00 pm, so requesting an evening appointment may involve a **longer wait period** to begin your counseling process.

DAY : M T W TH F 8:00 am to noon noon to 5:00 pm 5:00 to 9:00 pm

CHOOSE YOUR PAYMENT OPTION BELOW:

I am **ABLE** to pay the **\$80.00** for Clinical Counseling

I am **UNABLE** to pay the above fee and wish to apply for the **LOW-INCOME ADJUSTED FEE**. I understand I am required to **provide proof of income** and will bring my paystubs to my first counseling appointment, or if I do not have paystubs I will bring my federal tax return.

PRINT Name: _____

Signature: _____ **Date:** _____