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 apointment.**

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.

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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**:____________________