ctk Christ the King Community Church

Christ the King Church
4173 Meridian St.
Bellingham, WA 98226
(360) 733-1337

Date Received:____________

Counseling Application

Personal Information

First Last Middle

____

Mailing Address (Street or PO Box):

____

City/State/Zip:

____

Email Address:

____

Due to the nature of confidentiality, what is the best way to contact you?

Home phone:

____

Cell phone:

____

Work phone:

____

Household Members

Other adults living in household (include spouse, roommate, boyfriend/girlfriend, relative, friends, etc.)

First Name: _______________________ Last Name: ________________________

Date of Birth: _____________________ Cell Phone: _______________ Work Phone: __________________

Marital Status: __ Single __ Married __Divorced __ Separated __Widowed

What is their relationship to you? ____

Are they contributing to the household income? (circle one) YES NO

Insurance

Date of Birth________________

Employer______________________________________

Do you have medical insurance? ___ Yes ___ No

If Yes, please give providers name______________________

Please explain your insurance policy's coverage for counseling

____

____

____

How are you able to contribute to counseling costs at this time?

__ Partial payment

__ Nothing at this time

References

Please list 2 people at CTK, staff or regular attendees who can verify your need. Include phone number(s).	Relationship	Phone Number

To the best of my knowledge, the information on this application is true and complete.

______________________________ Signature of Applicant

______________________________ Date

Monthly Spending Worksheet

Section A - Sources of Income	Monthly
Income (list all household income)	
Child Support	
Food Stamps	
Income Total	

Section B - Housing	Monthly
Mortgage/rent	
Maintenance	
Storage rental	
Other:___________________________	
Housing Total	

Section C - Household Utilities	Monthly
Electricity	
Gas	
Water	
Sanitation	
Household Utilities Total	

Section D - Medical Exp. (Out of Pocket)	Monthly Payments
Doctors (including Specialists)	
Dentists	
Prescriptions	
Hospitals	
Therapy	
Medical Expenses Total	

Section E - Other Insurances	Monthly Payments
Medical	
Dental	
Disability	
Other:___________________________	
Other Insurances Total	

Section F – Debt * (list monthly payments & balances on page 4)	Monthly
*Credit Cards (total from page 4)	
*Other Debt (total from page 4)	
Debt Total	

Section G - Dependent Children	Monthly
Child Support Expense paid out for Dependent Children	
Child Care	
School Tuition/fees/supplies	
Activities/Sports	
Transportation	
Total Dependent Children Expenses	

Section H - Food	
Groceries and Household Supplies	
Fast Food/Work or School Lunches	
Specialty Coffee Drinks	
Food Total	

Section I - Transportation	
Automobile Payments	
Gas	
Insurance	
Maintenance/repairs	
Other:___________________________	
Transportation Total	

Section J - Communication Utilities	
Cell Phone (list # of phones on plan)	
Home Phone	
Cable/Satellite TV	
Internet Access	
Communication/Utilities Total	

Section K - Entertainment/Recreation	
Dining out (other than fast food)	
Babysitters (not daycare for working)	
Local Activities/trips	
Vacations	
Gym Memberships	
Entertainment/Recreation Total	

Section M - Pets	
Pet food	
Vet bills	
Pet Expenses - Total	

Section N - Miscellaneous	
Tithing	
Toiletries/Cosmetics/Personal Grooming	
Subscriptions	
Tobacco Products	
Other:____________________________	
Miscellaneous Total – Monthly	

Please complete the monthly income from Section A and monthly expenses from Sections B-N here.

TOTAL *INCOME* PER MONTH __________

TOTAL *EXPENSES* PER MONTH __________

Credit Cards, Loans or Other Debt

- **List all credit cards, bank loans or pay day loans**
- **List the monthly payments and balances owed**
- **Copy the monthly payment amounts into Section F of the Monthly Spending Worksheet above**

Credit Card, Bank or Pay Day Loans	Monthly Payment	Balance Owed
Totals		

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Counseling Referral Form

Contact Information

Client Name: ____
Phone #: ______________________ Email: ___________________________

Referral Information

***CTK may pay for up to 3-5 visits, up to maximum of $500.**

Referring Pastor: ______________________ Counselor Name: ______________________________

Note:

- *Number of visits or maximum dollar amount is not a guarantee and will be based on available funding.
- A Counseling application must be completed by client.
- To verify financial need, a brief screening will be conducted by The Blessing Coordinator.

Partial Payment Information

I, ________________________, agree to pay $_______ per visit, as a co-payment with Christ the King Community Church. **Note: Co-payments must be paid to counselor at time of service.**

Client Initials: ___________

Missed or Late Cancelation of Appointments

If you miss or cancel an appointment at the last minute, you will be responsible for payment of that appointment and we will not be able to pay for future visits.

Client Initials: ___________

Release of Information

I, ________________________, give permission to the counselor named above to release any necessary information or records to the referring CTK Pastor. I also give permission for CTK Care Team to share information with each other about my financial situation (not counseling) in order to expedite screening.

Client Signature: ____ Date: ____________
Referring Pastor Signature: ___________________________________ Date: ____________
Care Team Signature: _______________________________________ Date: ____________