



Financial Hardship Application

****Application Information based on client intending to receive services.***

****Signing this form gives us permission to audit at our discretion.***

COPY OF ID PROVIDED: Yes___ No___ (ID required)

First Name:_____ Middle Initial:_____ Last Name:_____ Date:_____

Employed (circle one): YES NO If no, explain reason:_____

If yes, place of employment:_____

Estimated annual income after taxes:_____

Number of People in Household (including self):_____

Reason for Financial Hardship (use back of form if you need more space to explain):_____

I wish to apply for the 605 Strong Voucher Relief Program: I am a (check any that apply):

Rancher/Farmer or Relative of Rancher/Farmer

Business Owner, Parent, Healthcare Worker, Nursing Home Resident, Survivor or Other Individual
Affected by the COVID-19 epidemic

Business Owner, Parent, Healthcare Worker, Nursing Home Resident, Survivor or Other Individual
Affected by the flooding or natural disasters of 2019

Experiencing current mental health or substance related issues and need funding to cover costs of
services

Individual whose out-of-pocket/co-pays on my insurance are beyond my means for payment

***If you checked any of the above, you may qualify for our grant relief fund to cover the costs of your services and may not have to compete for funding through our Non-Profit! Visit 605Strong.com for more information!**

Those who don't qualify for grant relief under the voucher program above may still qualify for assistance under our Non-Profit guidelines, continue to the next portion of the application.

Everyone, regardless of the funding source must sign below and agree to be bound by our terms and conditions before submitting this application!

List below ALL expenses/bills/debts owed per month. This is an estimate at the best of your ability.

Assets/Income	Bills	Debt

Total Expenses/Bills/Debts Per Month After subtracting from Income: _____

I understand that I will be required to fill out application for financial hardship every six months. I attest that everything stated on this form is true. I understand if information is found to be misrepresented, that one could be charged in a court of law if fraudulently representing self or others in household/dependents on this form.

Printed Name of Person Signing: _____

Client or Parent/Guardian Signature: _____ Date: _____

FOR OFFICE USE ONLY:

Client has been approved for forgiveness or reduction on current invoice for counseling services:

YES____ NO____

Amount deducted from current outstanding invoice: _____

Client has been approved for reduced fee per session for counseling services:

YES____ NO____

Fee per 50-60 minute Session: _____

Approved by Executive Director and Board President on behalf of Moore Thriving Communities:

Signature: _____ **Date:** _____

Signature: _____ **Date:** _____