CLIENT PROFILE

Name of Organization or Practice: _____ Clinician Name: _____

Address in which services will be provided:

_____

Street Suite City State Zip

Client Initials (First name and Last name initials only): ___ Age: ____ Gender: _____ Race:_____

Ethnicity: Non-Hispanic Military Status: No Military Status

Disability Status: Not Receiving Disability

Client location: County _____ State: _____ Zip Code: _____

Total household income: _____ Adults in the household: _____ Children under 18: _____

Female Head of Household: No Primary Language spoken: _____

Please briefly describe the history of child sexual abuse that is related to why the client is seeking treatment:

Please briefly describe why they are seeking services:

First projected date of treatment: _____

Does the client have insurance? No If yes, do you accept the clients insurance? No

Are you requesting a grant for: Co-Pay

If co-pay, total co-pay for each session: _____ If private pay, amount per session: _____
If deductible, what is the annual deductible amount? _____ When does the deductible renew? _____

Please describe why the client is requesting the grant funding:

Please describe your recommended course of treatment (frequency, duration):

How will the client be served beyond the grant funding, should services still be necessary?

Completed by: _____ Title: _____ Date: _____

For Change the Conversation to complete:

Reviewed By: _____ Date: _____ Approved: No ☐ Number of Sessions Approved: _____

Session Fee Approved: _____ Total Grant Award: _____ Date Funding Can Begin: _____

Unique Identifier: ____ MOU on file: No ☐ Clinician Profile on file: No ☐ Org Profile on file: No ☐