Institute for Therapy through the Arts

Financial Aid Application

NOTE: To determine eligibility for financial assistance toward ITA's services, you must verify your income at least every year. Your yearly income tax return, a copy of your W-2 form, your paycheck stubs from the 2 prior months, bank statements from the 3 prior months, copies of your social security checks, or other checks you may receive will provide sufficient proof. The amount of your annual income and the size of your family will be used to calculate your discount.

ATTENTION: If income verification is not provided on the day of application, you must provide it within 14 days of the application in order for the aid fee to be applied retroactively to your visit. Failure to provide income verification within the 14 days will result in the denial of your application and the cost of the visit will be solely your responsibility.

Today's Date: ____/____/_________

Patient Information					
First Name:	**Middle:**	**Last:**	**Other Names:**		
Home Address:		**City:**	**State:**	**Zip Code:**	
Mailing Address:		**City:**	**State:**	**Zip Code:**	
Home Phone #:		**Cell Phone #:**			
Date of Birth:	**Do you have insurance? (Circle One):** Yes No		**If yes, which provider?**		
Marital Status (Circle One):	Single	In a Relationship	Married	Divorced	Separated Widowed

Household Size	
Name:	**Date of Birth:**
Name:	**Date of Birth:**
Name:	**Date of Birth:**
Name:	**Date of Birth:**
Name:	**Date of Birth:**
Name:	**Date of Birth:**

(Flip for Household Income)

Household Income				
Individual	**Amount**	**Frequency (Circle One)**	**Name of Employer**	**Office Use Only: Initial & Date**
You	$	Weekly Monthly Yearly		
Spouse	$	Weekly Monthly Yearly		
Children	$	Weekly Monthly Yearly		
Other	$	Weekly Monthly Yearly		
TOTAL	**$**			

Other Income						
	You	Spouse	Children	Other	SUBTOTAL	**Office Use Only: Initial & Date**
Social Security	$	$	$	$	$	
Retirement Pension	$	$	$	$	$	
Child Support/Alimony	$	$	$	$	$	
Interest Income	$	$	$	$	$	
Unemployment	$	$	$	$	$	
Rentals	$	$	$	$	$	
Other	$	$	$	$	$	
TOTAL					**$**	

I declare that, to the best of my knowledge, the information on this application is true, accurate, and complete.

______________________________ ______________________________
Signature Date

FOR INTERNAL USE ONLY:
Therapist_________ Individual/Group_________ Prior Award_________ Current Award_________
Therapist_________ Individual/Group_________ Prior Award_________ Current Award_________
Therapist_________ Individual/Group_________ Prior Award_________ Current Award_________

ALL SUPPORTING DOCUMENTS WILL BE RETURNED ONCE REVIEWED. Additional information may be requested if necessary. If you have questions about the Financial Aid Program, please contact Marni Rosen, Psy.D, ATR-BC at (847) 448-8336 or mrosen@itachicago.org.