

Initial Financial Supplement Approval Form

Please complete the following application:

- LGBT Adult (Over 26 years old)
- Motivated for Treatment
- Capacity to Benefit
- Lacks sufficient financial resources to cover the cost of treatment

Age:
Gender:
Place of Residence (Borough):
Employment Status:
Occupation:
Medical Insurance Status:

List DSM-V Axis I/II Diagnosis
1.
2.
3.
4.

Describe financial hardships that would make this client eligible for Ray of Light Fund as well as plans for self-pay.

Describe client’s prior treatment history and outcomes, if applicable.

Describe agreed upon goals/objectives to be met during treatment.

Describe the recommended number of weekly/monthly sessions and type of services provided as well as recommended length of treatment**:

**The Ray of Light Fund can provide up to six months of financial subsidy with possibility of renewal

Date: