Grace's Haven Ministries

Mental Health Assistance Application

Purpose: Grace's Haven Ministries provides limited financial assistance to help individuals access mental health services. The information below is requested to verify financial need and maintain responsible charitable records.

1) Applicant Information

Full Name: _____

Preferred Name (if different): _____

Date of Birth: _____ / _____ / _____

Phone: _____

Email: _____

Address: _____

2) Household & Dependents

Number of people in household (including you): □1 □2 □3 □4 □5 □6+

Number of dependents you financially support: □0 □1 □2 □3 □4+

3) Household Income (Monthly Gross Estimate)

□ No current income

□ Under $1,000

□ $1,000–$1,999

□ $2,000–$2,999

□ $3,000–$3,999

□ $4,000–$4,999

□ $5,000+

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Primary income source(s): _____

4) Insurance Status

□ No insurance / self-pay

□ Insurance but cannot afford copay/deductible

□ Medicaid / Medicare

□ Other insurance: _____

5) Assistance Requested

Provider/Clinic/Pharmacy Name (if known):
_____

Type of Assistance Requested:

□ Intake/Assessment Fee

□ Therapy Sessions (number requested: _____)

□ Medication Management Visit(s)

□ Copay/Deductible Assistance

□ Medication Costs

□ Other: _____

Estimated amount needed (if known): $_____

6) Brief Financial Hardship Statement (1–3 sentences)

_____
_____
_____
_____
_____
_____

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7) Optional Documentation (Not Required)

□ Recent pay stub

□ Benefit award letter

□ First page of recent tax return

□ Other: _____

8) Applicant Attestation

I certify that the information provided is true and complete to the best of my knowledge. I understand that assistance is limited, not guaranteed, and is based on available funds, program guidelines, and the discretion of Grace's Haven Ministries.

Applicant Signature: _____

Date: _____ / _____ / _____

For Office Use Only

Date Received: _____

Approved: □ Yes □ No □ Partial

Amount Approved: $_____

Staff Initials: _____