University of Washington Counseling Center

Program for Financial Assistance (PFA) Application

 **INSTRUCTIONS**

* Complete each section of this form
* Attach a copy of your most recent (within 3 months) paystub
* Sign and date the completed application
* Return the application and pay stub via email to uwccbilling@uw.edu within 14 days of receiving the application

Client First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STUDENT ID #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:

Current Mailing Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_Apt#\_\_\_\_\_\_\_\_State\_\_\_\_Zip \_\_\_\_

Cell Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone\_\_\_\_\_\_\_\_\_\_\_\_

Employment status: Full time \_\_\_\_\_ Part time \_\_\_\_\_ Unemployed \_\_\_\_\_

What is your current monthly income from employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please attach a copy of your most recent (3 months) pay stub to this application**

Check here \_\_\_\_\_ if you aren’t able to provide the above documentation

Are you currently covered by any kind of health insurance: Yes No

If yes what is the name of your insurance carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you eligible for Medicaid Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_ I don’t know \_\_\_\_\_\_\_\_\_\_

**I certify, to the best of my knowledge that the information provided in this application is complete and accurate. I understand that providing false information on this application may result in denial of any form of financial assistance by University of Washington Counseling Center.** I am requesting financial assistance because I am unable to pay. **Initials:** **\_\_\_\_\_\_\_\_\_**

Print your first and last name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_

**For Office Use Only**

Application Taken by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Stamp

Application Approved by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Application Denied by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for denial: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Notified by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient notified by: PnC Message\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_