

Lacamas Counseling & Psychiatry
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LACAMAS
COUNSELING

Scholarship Application

Client Name: _____
Date of Birth: _____
Applicant/Guardian Name: _____
Relationship to Client: _____

Reason for Requesting Scholarship: _____

Monthly Income

Salary/Wages _____
Alimony/Child Support _____
Social Security/SSI/SSDI _____
Other _____

Total Income _____

Monthly Expenses

Mortgage/Rent _____
Loan(s) _____
Medical Insurance _____
Other _____
Grocery _____
Gas _____
Utilities _____
Child Care _____

Total Expenses _____

Number of People Supported by Income: _____

Based off of the above information, what do you believe that you can afford for professional therapy services. _____

I attest that the information identified on this scholarship application is true and reflective of the financial circumstances that impact me/my family.

If scholarship is awarded, I agree to notify Lacamas Counseling & Psychiatry if changes arise in my financial/life circumstances.

Print Name, Sign and Date Below:

Signed: _____

Date: _____