Sheryl A. Isaacs, MS, LMFT
Licensed Marriage and Family Therapist #92557
5523 Scotts Valley Drive, Scotts Valley, CA 95066
831-431-7996
www.therapyforyourchild.com

Renewal Date
_____

Name: _____ Date: _____
Address: _____ City: _____
Contact Phone Number: _____

Employer: _____
Spouse/Partner Employer: _____
Number of Dependents in home: _____
Ages of Dependents: _____

Types of Government assistance/help received monthly. Please check all that apply:

- □ Cash Aid Amount: _____
- □ Food Stamps Amount: _____
- □ Cal Works Amount: _____
- □ School Grants Amount: _____
- □ Low Income Housing Amount: _____

Monies from other sources
Please list all sources/amounts: (child support, alimony, parents, etc.)
_____
_____

Yearly combined net Income (before taxes): _____
Approximate monthly expenses that you must pay for: _____

Number of members of family seeking therapy: _____

Please explain any extenuating circumstances that may qualify you for a low fee slot:
For example: School loans, supporting elderly parents, child support, alimony
_____
_____
_____

Fee requesting to maintain weekly therapy sessions for self/family members: _____

Agreed upon fee: _____ _____ _____
Client Initials Therapist Initials

Fees will return to full fee after a three month period unless a new Low Fee Application Form is submitted. You may request another form from the Therapist as needed or print one from online at www.therapyforyourchild.com .

