



Church Assistance Program (CAP) Authorization Form

I, the undersigned, authorize Groff & Associates, LLC to provide professional mental health counseling services for the following congregational member(s):

MEMBER'S NAME _____

MEMBER'S NAME _____

STREET ADDRESS _____

STREET ADDRESS _____

CITY/ZIP _____ PHONE _____

CITY/ZIP _____ PHONE _____

EMAIL ADDRESS _____

EMAIL ADDRESS _____

Counseling services (___ sessions total) will be charged at a rate of \$_____ per session hour. The client is expected to pay \$_____ at the time of each counseling session and the church is to pay \$_____.

Groff & Associates will invoice the church monthly and be sent to the following address:

CHURCH NAME: _____

CONTACT/TITLE: _____

CITY/ZIP/PHONE: _____

EMAIL: _____

Any questions and invoices (mail or fax) should be directed to:

Groff & Associates, LLC
ATTN: Sally Groff, MA, LMFT, Clinical Director
7425 East 86th Street (Physical); PO Box 502246 (Mailing)
Indianapolis, IN 46256-1207 (46250-7246)

FAX: 317-578-0828
PHONE: 317-502-0330

Signature of Authorized Representative

Date

Printed Name of Authorized Representative