CHURCH ASSISTANCE PROGRAM AUTHORIZATION

I, the undersigned, authorize Groff & Associates, LLC to provide professional health care services for the following church member:

_____

CHURCH MEMBER'S NAME

_____

STREET ADDRESS

_____

CITY/STATE/ZIP

(_____)_____ _____

PHONE NUMBER **EMAIL ADDRESS**

Health care services (____ sessions total) will be charged at a rate of $_____ per session hour. The client is expected to pay $_____ at the time of each 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/STATE/ZIP: _____

PHONE: _____**EMAIL:** _____

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

Groff & Associates, LLC
ATTN: Sally Groff, MA, LMFT, Clinical Director
Physical: 7425 East 86th Street
Indianapolis, IN 46256-1207

FAX: 317-468-9905
PHONE: 317-474-6448 x101

_____ _____

Signature of Authorized Representative **Date**

_____

Printed Name of Authorized Representative