MAP REFERRAL AUTHORIZATION FORM

MEMBERSHIP ASSISTANCE PROGRAM

Our Organization, _____, authorizes Family Counseling Associates to send an invoice monthly for Professional Counseling and Psychiatric services for the person(s) noted below. The amount that our organization will cover per session is also indicated below. (Indicate -0- if you will not be paying for any portion of the client's treatment.

Name of Individual/Couple/Family Being Referred	**Amount Paid by** by Organization If Any	**Number of Approved** (Applicable Only If Organization Assisting with Fees)

PLEASE CHECK BELOW WHAT IS APPLICABLE FOR THIS MAP REFERRAL:

☐ The Referring MAP Organization will NOT be helping financially, but please allow the person(s) to be seen at our MAP rate for sessions.

☐ The Referring MAP Organization would request a Case Review after _____ sessions to consider continuing its Financial Assistance for the person(s)' treatment at FCA.

☐ Other Request(s): _____

_____

_____ _____

Signature of Authorized MAP Representative Date

THIS SECTION TO BE COMPLETED BY CLIENT AT THE TIME OF FIRST SESSION AT FCA

I authorize Family Counseling Associates to exchange the following information with the MAP Referring Organization regarding my Treatment:

☐ Session Dates and Services Provided for Billing Purposes (If MAP Organization will be providing Financial Assistance.

☐ Progress Reports concerning my Treatment upon Request by the MAP Organization.

_____ _____

Signature Client Receiving Treatment Date

_____ _____

Signature Client Receiving Treatment Date

Please Return Form By Fax (317) 585-9811 or Scanned Email Attachment to: Sarah@fcahelp.com