



CARLS CENTER FOR
CLINICAL CARE AND EDUCATION
**PSYCHOLOGICAL
TRAINING AND
CONSULTATION CENTER**
CENTRAL MICHIGAN UNIVERSITY

**Please attach supporting documentation of current income
(e.g., last year's tax return or W-2, paystub, etc.)**

SECTION 1	
CLIENT'S NAME:	
CLIENT'S DATE OF BIRTH:	
CLIENT'S ADDRESS:	
PHONE:	CMU STUDENT: YES ___ NO ___ IF YES, SKIP SECTION 2.
SECTION 2	
CLIENT IS CLAIMED AS A DEPENDENT ON ANOTHER PERSON'S TAX RETURNS? YES ___ NO ___	
If yes, the following questions should be based on the person(s) claiming the client on their tax returns. If no, the following questions should be based on the client's tax returns.	
NUMBER OF INDIVIDUALS IN THE HOUSEHOLD:	
NUMBER AND AGE OF DEPENDENT CHILDREN:	
OCCUPATION OF ADULTS IN THE HOUSEHOLD:	
GROSS ANNUAL HOUSEHOLD INCOME:	
OTHER INCOME (IF APPLICABLE):	
AMOUNT PAID THIS YEAR FOR CHILDCARE:	
ADDITIONAL INFORMATION:	
SECTION 3	
I CERTIFY THAT ALL INFORMATION ON THIS FORM IS ACCURATE TO THE BEST OF MY KNOWLEDGE.	
SIGNATURE:	DATE:
OFFICE USE ONLY:	
APPLICATION APPROVED: YES ___ NO ___ AMOUNT FOR SERVICES: _____	
OFFICE REPRESENTATIVE: _____ DATE: _____	