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Candidate Family Questionnaire – Counseling Services A.1

The mission of NeuroAlly Family Fund is to see neurodivergent individuals and families living happy, healthy, and productive lives and to provide a financial bridge and a spectrum of creative solutions that foster awareness, empathy, and healthy interactions for neurodivergent individuals and families.

In order to do that, we need some information about your family. All information provided will be kept confidential in accordance with HIPAA regulations. Thank you for your time and willingness to share!

Family Introduction

1. How many members in your family are seeking counseling services?

2. What are the ages and genders of the individuals seeking counseling services?

Counseling Services

3. What counseling services are you seeking and why?

4. What service provider are you looking for utilizing these counseling services?

5. What behaviors or challenges have led you to seek counseling services at this time? Please describe three instances of those behaviors or challenges.

Financial Considerations

6. Does your current insurance plan cover any portion of family counseling services for your family situation? If so, what percentage or amount does your insurance cover?

7. How would receiving financial assistance for counseling services from NeuroAlly Family Fund impact your family?

8. Are you willing to sign a contractual agreement that NeuroAlly Family Fund will pay the counseling service provider directly on behalf of your family and give you a receipt?

Other Information

9. Is there any additional information that you would like to share about your family at this time?

10. How did you hear about NeuroAlly Family Fund?

CONTACT INFORMATION:

First Name:
Last Name:
Email:
Phone:

By signing this document, I declare that the information provided is accurate and complete:

____________________________ _______________

Signature Date