SCHOLARSHIP FORM

Redemption
CHRISTIAN COUNSELING

4910 Stack Blvd., Suite D-3
Melbourne, FL 32901 (321) 626-4095

CLIENT NAME:_____ COUNSELOR:_____

Rent - Mortgage	
Car Insurance	
Taxes	
Utilities	
Cable & Phone	
Gas & Tolls	
Groceries	
Child Care	
Health Insurance	
Car Payments	
Credit Card Payments	
Medical Bills & Medications	
Others:	
TOTAL MONTHLY EXPENSES	

Wages (Yourself)	
Wages (Your Spouse)	
Child Support	
Alimony	
Savings	
Investments	
Other Household Income	
TOTAL MONTHLY INCOME	

- **Current Sale Value of Home $_____**
- **Will Health Ins. cover any of the cost of counseling? If so, how much _____**
- **Do finances create a problem in your life? If so, please explain.**
- **Will an individual, organization or group be helping to financially support your counseling? Please explain.**

_____
_____
_____
_____
_____
_____
_____
_____

By signing below, I acknowledge that the information provided is accurate and complete.

Signed: _____ Date: _____

Office Use Only

Counselors Recommendation: _____

Board Decision: _____ Date: _____