

Bishop's Assistance Form

Name of Family Members receiving Therapy: \_\_\_\_\_

Date: \_\_\_\_\_

Bishop's Name: \_\_\_\_\_

Bishop's Email & Phone #: \_\_\_\_\_

Ward/Stake: \_\_\_\_\_

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**BISHOP COMPLETES BOTTOM PORTION**

Check Length of Treatment:

\_\_\_\_\_ 1 session (therapist to consult with bishop following session)

\_\_\_\_\_ 12-16 sessions (average length) \_\_\_\_\_ At therapists' discretion (communicate treatment plan with Bishop)

Therapy is \$75/session

Circle Bishop's Contribution: \$75 \$50 \$25

Ward Member Contribution (remainder of \$75; it's recommended that members contribute at least \$25 if possible): \$ \_\_\_\_\_

Address to send monthly bill to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Bishop's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

