PSYCHOLOGICAL SERVICES FUND
APPLICATION FORM

APPLICANT SEEKING TREATMENT			
NAME of the Psychologist or CMHA worker applying for funds			
COMPANY OR FIRM (if applicable)			
ADDRESS			
PHONE NO.	( )	FAX NO.	( )
EMAIL			
NAME of the Client for whom psychological services are sought			
Client address			
Client phone no.	( )		
❑ One-time assessment ❑ Series of counselling sessions			
I have read and understand the attached information sheet, attest to the client's financial need, and am a member of the PAA (for psychologists)			
SIGNATURE		DATE	

Mail, email or fax to:

Mara Grunau
Chief Executive Officer
Canadian Mental Health Association, Alberta Division
and Centre for Suicide Prevention
Clo Psychologists' Association of Alberta 101, 1259 -91 Street SW
Edmonton, AB T6X 1E9

Tel (780) 424-0294
Toll Free 1-888-424-0297
Email: paa@paa-ab.ca

For office use only			
CANADIAN MENTAL HEALTH ASSOCIATION, ALBERTA DIVISION AND CENTRE FOR SUICIDE PREVENTION - APPROVAL			
YES ❑ NO ❑			
SIGNATURE OF EXECUTIVE DIRECTOR		DATE	
NO. ASSIGNED TO APPLICANT			