SCHOLARSHIP APPLICATION

Last Name:	First:	MI:
Parent/Guardian Last Name:	First:	MI:
Parent/Guardian Last Name:	First:	MI:
Daytime Phone:	Evening Phone:	
Client DOB:	Client SSN:	Parent / Guardian SSN:
Parent / Guardian DOB:		

Marital Status

Client/Parent/Guardian	☐ Married	☐ Never Married	☐ Divorced	☐ Separated	☐ Widowed

Employment

Client/Parent/Guardian	☐ Full-time	☐ Part-time	☐ Temporary	☐ Retired	☐ Unemployed
If unemployed, date of last employment:			Date due to return to work:		
Present Employer:			Previous Employer:		
Job Title:			Job Title:		

Client / Parent / Guardian Income over past 30 days

Job: $	Spouse or live in partner: $	Unemployment: $	Child Support: $
Retirement: $	Food Stamps: $	SSI: $	Other: $

Do you have:

☐ Health Care Insurance	☐ Medicaid	☐ Medicare	☐ Harris County Gold Card

Other Dependents and / or Children

Number:	Ages:
Number living in household:	Number providing support for:

Housing:

☐ Own	☐ Rent	☐ Live with relatives	☐ Shelter	☐ Homeless

Amount Paid each month for:

☐ Housing: $	☐ Utilities: $	☐ Major Medical: $	☐ Child Support: $

Please explain your hardship/circumstances that you believe qualifies you for treatment & funding assistance:

Throstur Bjorgvinsson 3/7/2014 3:15 PM
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Please list all past and current mental health providers (including any intensive treatment programs or hospitalizations). Completing attached release forms will assist in the evaluation process, as contact with providers is part of the selection proceedings and ongoing services of the scholarship program.

Name	Month/Year of services	Approx # sessions

Please fill out the below information to the best of your ability:

Describe your therapy experience with the providers you mentioned above, including why you stopped treatment, what treatment progress you made, etc.

Describe any OCD or Anxiety related concerns (symptoms?):

Mood related concerns:

Have you experienced any suicidal ideation/gestures/acts and/or engaged in any self-harm behaviors? If so, please provide more information and the date of last occurrence.

Substance Abuse/Dependence related concerns (past or present):

Treatment Goals (Why you think you would benefit from treatment?):

I certify that the above information is accurate and true:

Signed:		Date:	

(Do not mark below this line)

Date Received:	Client Contacted (date):
Approval: Yes or No	Session Amount Agreed Upon: