BREATHE GIVES BACK APPLICATION

<u>SCHOLARSHIP APPLICATION</u>**:** In order to apply for Scholarship Funding, please complete the following application and submit the application with your application package.

Full Name of Person Seeking Treatment: ____ **DOB:** _________________

Applicant Phone: _____________________________ **Applicant Email:** ___________________________________

Applicant Street Address: ____

City: ____ **State:** ______________ **Zip:** ____________________

Name of individual paying if different from above: ___________________________ **Relationship:** __________________

How did you hear about this program? ____

Please list current therapist or other treating professional(s): ____

Preferred Initial Length of Stay: ___30 Days ___45 Days ___60 Days ___75 Days ___90 Days

Preferred Admit Date: ___________________________

Annual income as shown on last year's tax return: $__________________

* Income requested is for individual seeking treatment. Income verification may be requested.

What amount are you able to contribute to your treatment? $____________________

Amount of financial assistance you're seeking: $______________________

If approved for financial assistance, how do you plan to pay for the remainder of your program?

Briefly explain any extenuating circumstances that would lend to your need for financial assistance: