L. Stanley Haywood Recovery Fund Scholarship Application

Please fill in the following information and submit to NCPHP by contacting Kim Lamando at kim@ncphp.org or by faxing it to 919-870-4484.

Note: You must fill in all the required information or the application will not be submitted or may be returned to you.

Types of Scholarships Available:

Assessment Scholarship ($2,500 – limit one per calendar year)

Outpatient Therapy Scholarship ($2,500 – limit one per calendar year)

Residential Treatment Scholarship ($5,000 – limit one per calendar year)

Name: ____ DOB: __________________

Address: ____

Email: ____ Phone: ______________________

Last four digits of Social Security #: ___________________________

Current/most recent employer: ____

Dates of employment: ____

Attestation

By signing below, I declare, to the best of my knowledge and belief, that the above information is true correct, and complete.

Signature: ____ Date: _________________

This page is reviewed by NCPHP Administrative Staff Only (not seen by reviewing Committee members)

DOB: Last 4 of SS #:

Please check the type of scholarship you are applying for:

Assessment Scholarship ☐

Outpatient Therapy Scholarship ☐

Residential Treatment Scholarship ☐

Please check one:

Pharmacist ☐ Technician ☐ Student ☐

Pharmacy technicians are eligible for the scholarship if they have been registered with the NCBOP for a minimum of five years AND if they have been employed as a technician with their current/most recent employer for the past two years. Applications are only submitted for approval once this information has been verified.

Financial Information

1. Are you currently working? Yes ☐ No ☐
   If not, when you expect to return to work. Date: ____________________
2. Number of members in household: ________________________
3. Current monthly gross household income: _________________________
4. Do you rent or own your home? Rent ☐ Own ☐
5. What are your monthly household debts?
   a. Mortgage/rent: ____
   b. Car Loans: ____
   c. Student Loans: ____
   d. Business Loans: _______________________________________
   e. Credit Card(s): _______________________________________
   f. Other debts: ____
6. What liquid assets are available for use for treatment? ______________________________
   ____
   ____
7. Are other financial resources available to assist? Yes ☐ No ☐
   If yes, please explain ____
   ____
   ____
8. Please describe your financial circumstances to help us understand your situation: __________
   ____
   ____
   ____
   ____

DOB: Last 4 of SS #:

Provider Information

1. Provider (Assessment/treatment center, therapist, etc.) Name: ______________________________
   ____
2. Contact Person:____
3. Address: ____
4. Email Address: ____
5. Telephone: ________________________________
6. Admission/Start Date: ______________________

Administrative Use Only

Debt to Income Ratio: _______________

Approved ☐

Check #: ____________________ Check issued date: __________________________

Denied ☐

Date: ______________________________