



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 or 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: _____