



L. Stanley Haywood Recovery Fund Scholarship Application

Please fill in the following information and submit to NCPHP by emailing Kim Lamando at kim@ncphp.org or by faxing 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 Pharmacy Technician Assessment Scholarships are limited to \$750.

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: _____

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 ALL three criteria are met:

- 1. They are registered with the NCBOP as a "certified technician"

I am certified through: PTCB ExCPT

- 2. They have been registered as a technician with the NCBOP for a minimum of five years

Date of NCBOP technician registration: _____

- 3. They must have been in their current pharmacy technician employment position for at least two years.

Date of hire in current technician employment: _____

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? _____

DOB:

Last 4 of SS #:

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: _____

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: _____