L. Stanley Haywood Recovery Fund Scholarship Application

Please fill in the following information and submit to NCPHP by contacting Beth Byarlay at bbyarlay@ncphp.org or by faxing it to 919-341-9930.

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: _____

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 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? _____
   _____
   _____

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: _____