# CLAYTON CENTER

## FINANCIAL ASSISTANCE SCHOLARSHIP PROGRAM APPLICATION

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|---|---|
| **Date** | / / |
| **Name** | |
| **DOB** | / / |
| **Address** | |
| | |
| **Telephone Number** | ( ) - |
| **# Of Individuals Living in Household** | |
| **Are you currently employed?** | ☐YES ☐ NO |
| **Are you lawfully in the USA?** | ☐YES ☐ NO |
| **Do you have Health Insurance?** | ☐YES ☐ NO |
| **If so, what type** | |
| **Do you have a Primary Care Physician?** | ☐YES ☐ NO |
| **If so, please list name and phone number** | |
| **What kind of assistance are you applying for?** | ☐ Co-Pay ☐Treatment Cost |
| **What is your current diagnosis?** | |
| **What Prescription Medications are you currently prescribed?** | |
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| **How long have you been a Clayton Center client?** | |
| **In a few words, tells us why you need financial assistance?** | |
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| ***INTERNAL USE ONLY*** | |
|---|---|
| **Type of Assistance** | ☐ Co-Pay ☐Treatment Cost |
| **Insurance Coverage Verified** | ☐YES ☐ NO |
| **Legal Residency Verified** | ☐YES ☐ NO |
| **Initial Date of Services** | / / |
| **Application Status** | ☐APPROVED ☐DENIED |
| **Date of Contact with Client** | / / |
| **Application Reviewed by** | |
| **Application Reviewed on** | / / |