



CarePossible

Application for Assistance

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I. OVERVIEW

CarePossible is a nonprofit organization dedicated to making care possible for individuals struggling with mental health or addiction issues who want and need treatment, but cannot afford treatment. Individuals in need of care shall completely fill out this application to determine whether they are truly ready for help, whether they have any other means of assistance, and what type of help is best for them. Those approved for funding will be sent to the appropriate treatment professional or treatment program.

Mission of CarePossible: To provide quality mental health care and addiction treatment for those who want help and need help, but lack financial means.

Vision of CarePossible: The vision of CarePossible is to make care possible for those in need of mental health or addiction treatment, but who are unable to afford it. CarePossible will partner with top treatment centers and mental health care professionals in order to provide the very best of care. We are all about saving lives, saving families, and offering hope to the hopeless. We seek to serve all, and have a special passion for military families and low income families.

II. CAREPOSSIBLE GUIDELINES

Please read carefully and initial before completing and submitting this Application.

Initials:

- _____ 1. Funding assistance is for low income individuals/ military/ and families. Proof of income, medical history, and financial documents will be required to receive assistance.
- _____ 2. The purpose of the application is to determine the need for treatment as well as the recommended course of treatment.
- _____ 3. If approved payment will only be made directly to the treatment professional.
- _____ 4. Requests will receive a response within 1 week from the receipt of completed application. (Incomplete applications will be returned to the applicant.)
- _____ 5. A potential client must first go to family members for assistance before he/she will be considered for Care-Possible assistance. (If a potential recipient will not go to family members for financial support, there must be an adequate reason.)
- _____ 6. Potential clients must be willing to make the necessary arrangements to meet with the counselor. Failure to commit to the scheduled appointment times may result in the cancellation of continued funding for services. If the review board determines that a personal problem is involved in the financial crisis, counseling may be recommended (financial, family, emotional, etc.) If recommended, the review board may assist the recipient in locating an alternative funding.)
- _____ 7. The review board has the right to refuse assistance to anyone.
- _____ 8. If for any of the above reasons a person does not qualify for financial assistance for services, members of the review board may guide him/her in going to the appropriate organizations for assistance.

I, the undersigned, have read and agreed with CarePossible's application Guidelines before completing this application. I also understand that the review board will hold all information with the utmost of confidentiality.

Signature _____ Signature _____

Printed Name _____ Printed Name _____

Date _____ Date _____

(To be signed by Spouse if application is being made by a married couple or Parent/Guardian if for a minor.)

Upon fully completing this application, please return to:

CarePossible, Inc.
28801 Via Pasatiempo
Laguna Niguel, CA 92677

CarePossible Application

For Office Use Only Submission Date ___/___/___ Date Approved for Processing ___/___/___ Approved by _____

Please attempt to answer all questions on this form. While we realize that many are of a personal nature, the more specific the information, the easier it is for us to evaluate your situation.

III. PERSONAL INFORMATION

Male Female

Name: _____ Date: _____

Address: _____ Years: _____

Social Security No: _____ Birth Date: ___/___/___ Age: _____

Phone: _____ Email Address: _____

EDUCATION

Last School Attended: _____ Degree/ Certificate : _____

Did you graduate? Yes No Year Graduated: _____

Other trade/business schools or certificates: _____

IV. COUNSELING HISTORY

Have you been ever in your lifetime been treated for a mental health issue or substance abuse? Yes No

How long did you receive treatment? When?

Were you given financial assistance? Yes No

If yes, from whom? _____

If no, how did you pay for it? _____

Are currently working with a counselor, therapist, or physician? _____

Their name? _____

Are you in a support group? Yes No Leaders Name? _____

Are you also seeking care from other institutions, if so which ones? _____

Do you have health insurance? Yes No What is your co-pay? _____

Have you applied for government assistance? _____

Are you currently in a program? Yes No Facility name? _____

Are you taking medication? Yes No

Which ones? and how long? _____

Briefly describe your current situation: _____

What events occurred to prompt you to seek aid from CarePossible: _____

Have you previously applied for CarePossible? Yes No If yes, when? _____

Have you made a request for financial assistance from any other party/group? _____

If Yes, please specify dates, organization and amounts: _____

Who referred you to CarePossible? Name: _____ Phone #: _____

V. FAMILY

Marital Status: Single Engaged Married Separated Divorced Widowed

Spouse's Name: _____ Age: _____ Male Female

Contact Phone Number: _____ (please provide if different)

Dependent's names and ages:

Male Female Birthdate: _____ Age: _____ Home

Male Female Birthdate: _____ Age: _____ Home

Male Female Birthdate: _____ Age: _____ Home

Male Female Birthdate: _____ Age: _____ Home

Male Female Birthdate: _____ Age: _____ Home

Does your family of origin have the means to help you? Yes No

Have you contacted your family members regarding your need? Yes No

(please be sure to read #7 of CarePossible application Guidelines on page 1)

Are they able/willing to help? Yes No If no, please explain why? _____

VI. EMERGENCY CONTACTS

Please list two individuals who can be notified in the event of an emergency.

Name: _____ Relationship to Applicant: _____

Home Phone: _____ Work: _____ Cell: _____

Name: _____ Relationship to Applicant: _____

Home Phone: _____ Work: _____ Cell: _____

VII. EMPLOYMENT HISTORY

IF YOU HAVE A RESUME, PLEASE ATTACH FOR REFERENCE

Present Employer: _____ From: _____ To: _____

Position: _____ Salary: _____

Address: _____ Phone: _____

Previous Employer: _____ From: _____ To: _____

Position: _____ Salary: _____

Address: _____ Phone: _____

Reason for Termination: _____

Previous Employer: _____ From: _____ To: _____

Position: _____ Salary: _____

Address: _____ Phone: _____

Reason for Termination: _____

VIII. FINANCIAL INFORMATION (Please fill in all information that applies to you. Write N/A if it does not apply.)

Are you currently in the military or are you a veteran? Yes No If yes, please skip to Section IX.

Gross Monthly Income

Source	Amount	Source	Amount
Employment Income		Social Assistance (Food Stamps, Welfare, etc.)	
Spouse Income		Rental Income	
Overtime Bonus, Commission		Other (Alimony, Child Support, etc.)	

Monthly Expenses (Please be specific as possible)

Type	Owed To	Monthly Payment	Balance Owed	Interest Rate
Rent/Mortgage				%
Auto				%
Taxes / IRS Debt				%
Personal Loan				%
School Loan				%
Utilities: Heating				%
Electric				%
Phone				%
Cable				%
Credit Cards:				%
				%
				%
				%
Other (List All)				%
				%
				%
				%

Assets

Type	Value	
Checking Accounts Total		
Savings Accounts Total		
Cash On Hand		
Property / Home Value		
Trust Funds / Stocks / Bonds		
401K / IRA		
Life Insurance		
Credit Union		
Automobile #1		Yr. / Make
Automobile #2		Yr. / Make
Personal Property		
Other		

Please list other sources of assistance that you have sought (parents, family, loans, sale of personal property, social programs).

Are you willing to share all your financial details (in confidence) with a CarePossible representative? Yes No

Are you interested in additional family counseling? Yes No

X. AGREEMENT MY (OUR) AGREEMENT WITH CarePossible

I (we) have read and understand CarePossible application guidelines. I (we) am (are) willing, to accept assistance as a gift and understand that repayment is neither necessary nor expected. I (we) understand that the review board may verify any information as part of determining whether or not CarePossible review board will meet my (our) need. I (we) understand that CarePossible review board and/or volunteers will attempt to assist me (us) in developing a plan, and that they do not make any representations or warranties with respect to the results of their services and/or referrals or their ability to help me (us) with my (our) needs. I (we) further agree to indemnify and hold harmless all staff and/or volunteers of CarePossible and its employees, agents, counselors, consultants, officers, and directors from any claim, suit, action, demand, or liability of any kind and any nature arising out of or in any manner connected with my (our) participation in these services. I (we) hereby certify that the answers and other information on this application are true and correct and that I (we) understand any misrepresentation or omission of facts on my (our) part will disqualify me (us) from this service.

Signature _____ Signature _____

Printed Name _____ Printed Name _____

Date _____ Date _____

(To be signed by Spouse if application is being made by a married couple or Parent/Guardian if for a minor.)