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.
28202 Cabot Rd., Suite 300
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: _____

Street Address: _____ Years at address: _____

City: _____ State: _____ Zip Code: _____

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

Phone: _____ Email Address: _____

**The following information is required for grant purposes.**

How many in household? _____ Female head of household? Yes ❑ No ❑ Disabled? Yes ❑ No ❑

**Ethnicity/Race** (check one)

❑ Hispanic, or Latino, of any race

❑ Native Hawaiian or Pacific Islander, not Hispanic or Latino

❑ Asian, not Hispanic or Latino

❑ American Indian or Alaska Native, not Hispanic or Latino

❑ Multiracial, not Hispanic or Latino

❑ Black or African American, not Hispanic or Latino

❑ White, not Hispanic or Latino

## EDUCATION

Last School Attended: _____ Degree/ Certificate : _____

Did you graduate? Yes ❑ No ❑ Year Graduated: _____

Other trade/business schools or certificates: _____

## IV. COUNSELING HISTORY

Have you 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 occured 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 (CalFresh and/or other services) | |
| 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 ❑

**IX. 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.)