Application for Financial Scholarship

**2022**

WE ARE HERE. WE CAN HELP

[www.thesobrietyresource.org](http://www.thesobrietyresource.org)

Table of Contents

[WELCOME AND INTRODUCTION 2](#_Toc114065314)

[ELIGIBILITY AND REQUIRED DOCUMENTATION 3](#_Toc114065315)

[PERSONAL INFORMATION 4](#_Toc114065316)

[SCHOLARSHIP STATEMENT 7](#_Toc114065317)

[SCHOLARSHIP AGREEMENT 8](#_Toc114065318)

[DECLARATION OF FINANCIAL NEED 9](#_Toc114065319)

[VERIFICATION OF HOMELESSNESS 10](#_Toc114065320)

[GENERAL RELEASE OF LIABILITY 11](#_Toc114065321)

[AUTHORIZATION TO RELEASE PERSONAL INFORMATION 12](#_Toc114065322)

APPENDIX A: EXAMPLES OF HOMELESS STATUS AND THIRD-PARTY VERIFICATION

# WELCOME AND INTRODUCTION

**A picture containing vector graphics

Description automatically generated**

Thank you for considering **The Sobriety Resource** to serve you in this time of need. We are a private non-profit organization that promotes the recovery of those that struggle with substance use disorder and the families that are affected.

We are community-based and believe that programs and services should be available to everyone. We also know that addiction is chaotic and messy and that there are no cookie cutter solutions. Our goal is to help individuals and families connect to ethical and trustworthy treatment and recovery providers who can meet their unique needs.

Because of the generosity of public and private donors, **The Sobriety Resource** can offer services free of charge to qualified applicants. We are fortunate to have advocates, volunteers and allies in the community who are willing to help us reach and assist people in need of our services.

**Financial assistance, however, is subject to the availability of funds**, so unfortunately not every scholarship application can be approved.

Scholarships for an individual can be **awarded once per year**. Extenuating circumstances may be taken into consideration but must be fully explained in the application and supported with valid documentation. All subsequent financial assistance is solely at the discretion of our Board of Directors.

Thank you for allowing us to serve as your trusted addiction and recovery resource connection. We hope we can accommodate your request and look forward to being a part of your recovery journey.

Please review the following pages and complete and return all required documents to [**info@thesobrietyresource.org**](mailto:info@thesobrietyresource.org). If you have any questions, or need to speak a member of our team, please contact us at 404-952-0363.

# ELIGIBILITY AND REQUIRED DOCUMENTATION

To begin the process of qualifying for scholarship consideration, you must **submit a completed application**, which includes all required supporting documentation.

**CHECK LIST OF REQUIRED SCHOLARSHIP APPLICATION DOCUMENTS**:

Completed Financial Scholarship Application (Signed and Dated)

Copies of Identification (State issued ID or DL, Jail ID, SS Card, Birth Certificate)

Declaration of Financial Need (Signed and Dated)

Letter of Acceptance from Recovery/Treatment Provider

Verification of Homelessness (if applicable) / Proof of Current Living Situation

General Release of Liability Form

Authorization to Release Personal Information Form

Proof of Income / Verification of Financial Need

**Please provide all applicable documentation that can be used to provide an accurate snapshot of your current financial situation**

Last 2 Pay Stubs (if applicable)

Previous Year’s IRS Form 1040, if applicable

Income / Wages Report

* + [Transcript Types and Ways to Order Them | Internal Revenue Service (irs.gov)](https://www.irs.gov/individuals/transcript-types-and-ways-to-order-them)
  + [Get Transcript FAQs | Internal Revenue Service (irs.gov)](https://www.irs.gov/individuals/get-transcript-faqs#online)

Evidence of Department of Labor Unemployment Filing, if applicable

* + [Georgia Department of Labor](https://dol.georgia.gov/)

Evidence of Child Support Payment, if applicable

Evidence of Child Support Receipt, if applicable

Evidence of any other Income/Expenses (as described on financial worksheet)

**IMPORTANT:**

* The Sobriety Resource does not hold scholarship openings.
* Available scholarship funds **are limited** and offered on a **first come, first-served basis** until monthly funds are exhausted.
* **Incomplete applications will be returned** to you (along with a list of missing information) and **will not be processed until all required documents are received**.
* All **completed scholarship applications** will be reviewed in the order they are received.

# PERSONAL INFORMATION

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| FIRST NAME: | X | | MIDDLE: | | X | | LAST: | X |  |
| SSN: | X | | GENDER: | | X | | DOB: | X |  |
| ETHNICITY: | African American  Asian  Caucasian  Latino  Other: X | | | | | | | |  |
| LAST ADDRESS: | | X | | | | | | |  |
| CITY / ST / ZIP: | | X | | | | | | |  |
| PHONE NUMBER: | | X | | EMAIL: | | X | | |  |

Are you a Veteran?  Yes  No

Do you have health insurance?  Yes  No

Are you affiliated with a religion? If so list: X  Prefer not to answer

**FAMILY BACKGROUND: Please provide names and age(s) of all that apply.**

|  |  |  |
| --- | --- | --- |
| **RELATIONSHIP** | **NAME** | **AGE** |
| Spouse | X | X |
| Parent | X | X |
| Parent | X | X |
| Child/Dependent | X | X |
| Child/Dependent | X | X |
| Child/Dependent | X | X |
| Child/Dependent | X | X |

**CURRENT LIVING SITUATION**

Are you currently homeless?  Yes  No

**IF YES:** How many times have you been homeless in the past three (3) years? Enter text here

**IF NO:** Where have you been living for the past 30 days?

Apartment (I have been leasing in my name)

Home (I own or have a mortgage in my name)

Living with friends or relatives

Hotel / motel

Recovery/treatment program

Emergency Shelter

Domestic Violence Shelter

Jail / Correctional Institution

Mental Health Facility

Detox Center / Crisis Stabilization Unit

Other: Please name Enter text here

**SUBSTANCE ABUSE HISTORY**

Which of the following substances have you used at any time in the past?

(Please check all that apply)

Alcohol

Marijuana

Cocaine

Crack

Heroin

Oxycontin or Oxycodone

Methamphetamine

Benzodiazepine

Other: Enter text here

How old were you when you first used alcohol or controlled substances? Enter text here

What is your preferred substance(s) Enter text here

Which substance(s) have you used most recently? Enter text here

**RECOVERY HISTORY**

Have you been in a recovery/treatment program in the past?  Yes  No

IF YES:

What is the total length of time you have spent in recovery programs? Enter text here

Please list the name(s) of the program(s) you have attended in the past and the dates you attended.

Enter text here

Did you complete any of the programs you were in?  Yes  No

Have you participated in AA or other self-help meetings?  Yes  No

**EMPLOYMENT INFORMATION**

What is your current employment status?  Unemployed  Employed

|  |  |  |  |
| --- | --- | --- | --- |
| Employer Name: | X | | |
| Address: | X | | |
| City / ST / Zip Code: | X | | |
| Work Phone: | X | Status: | Full-Time  Part-Time | |
| Supervisor Name: | X | Title: | X | |

|  |  |  |  |
| --- | --- | --- | --- |
| Spouse Employer: | X | | |
| Address: | X | | |
| City / ST / Zip Code: | X | | |
| Work Phone: | X | Status: | ❑ Full-Time ❑ Part-Time | |
| Supervisor Name: | X | Title: | X | |

**Income/Expense Worksheet (Please Print Clearly)**

\*If you are unemployed, have your parents complete this section or explain how you have been supporting yourself in the “other expenses” area.

**MONTHLY INCOME**

|  |  |
| --- | --- |
| Your Gross Monthly Income | $ X |
| Your Spouse’s Gross Monthly Income (If applicable) | $ X |
| Child Support Received (If applicable) | $ X |
| State or Federal Assistance (If applicable) | $ X |
| Food Stamps Assistance (If applicable) | $ X |

**MONTHLY EXPENSES**

|  |  |
| --- | --- |
| Rent / Mortgage Payment | $ X |
| Automobile Loan | $ X |
| Utilities (Electricity/Water/Gas/Etc. | $ X |
| Phone | $ X |
| Child Care | $ X |
| Child Support | $ X |
| School Tuition / Loan | $ X |
| Other (Please Explain below):  Enter text here | $ X |

How often are you paid?  Weekly  Bi-Weekly  Monthly  Twice a Month

Do you share expenses with anyone living in your household?  Yes  No

Total number of persons living in your house? Enter text here

**NOTE: To process your application, we must have at least one of the following:**

1. If you are working or retired with benefits: Prior year’s tax form 1040 (first 2 pages)
2. If you are unemployed: Proof of unemployment benefits
3. If you are disabled: Proof of disability benefits
4. If you are SSI or SSA benefits: Proof of Social Security benefits

# SCHOLARSHIP STATEMENT

To help us better understand your situation, and ensure we provide the best possible recovery options, please answer the questions below. This information is confidential and will be used solely to process your scholarship application.

1. Have you received funding from The Sobriety Resource previously?   Yes  No
2. How did you hear about The Sobriety Resource? (i.e., Website, google search, friend/relative (include name), program/agency (include name), other (please specify)

Enter text here

1. Which program / services have you applied for and why?

Enter text here

1. What do you hope to gain through your participation in this program or through these services? (What are your goals/expectations? How will you measure your progress?)

Enter text here

1. List 3 areas that you will work on during your participation in the recovery process.

Enter text here

1. Give us a brief description of what has happened in your past to bring you to this point in your life. Please be as detailed as possible.

Enter text here

1. How will this assistance help you in your recovery? How will this assistance impact your futures hopes and plans?

Enter text here

# Scholarship Agreement

I Enter name here hereby certify that the above information is true and complete. I agree to inform The Sobriety Resource immediately of any changes in the above information. I understand that false information will jeopardize my scholarship assistance.

I hereby give permission to The Sobriety Resource and its representatives to contact individuals or employers for salary and bill verification, as well as to conduct a credit and/or criminal background check.

In order to maximize what The Sobriety Resource is able to offer, I understand that I will be asked to pay a percentage of my program fees.

**SIGNED:** Enter FULL NAME HERE **DATED**: Enter Date Here

Applicant Signature

NOTE: By typing and submitting your name in this document, you are certifying that you have read, understand, and agree with the above information as submitted by you to The Sobriety Resource.

**OFFICE USE**

SIGNED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATED: Enter date here

TSR Representative Signature

# declaration of FINANCIAL NEED

**CERTIFICATION FROM APPLICANT**:

I, Enter name here, certify that I am currently in need of professional substance use disorder treatment and/or recovery services, and that I currently do not have the financial means to secure these services for the following reasons:

Enter text here

[NOTE: Please include information about your current living situation and employment status, as well as any family or support agencies who can provide verification of your current situation]

I understand that I am required to provide documentation that supports my request for financial services, and I give The Sobriety Resource permission to verify any third-party information I provide (if needed).

**SIGNED:** Enter FULL NAME HERE **DATED**: Enter Date Here

Applicant Signature

NOTE: By typing and submitting your name in this document, you are certifying that you have read, understand, and agree with the above information as submitted by you to The Sobriety Resource.

# VERIFICATION OF HOMELESSNESS

**CERTIFICATION FROM APPLICANT**:

I Enter name here, certify that ***I am currently homeless*** and do not have the financial means to secure housing for the following reason(s):

Enter text here

[NOTE: Please be as detailed as possible and include backup documentation from support agencies or community resource providers who can verify your homeless status]

**SIGNED:** Enter FULL NAME HERE **DATED**: Enter Date Here

Applicant Signature

NOTE: By typing and submitting your name in this document, you are certifying that you have read, understand, and agree with the above information as submitted by you to The Sobriety Resource.

# general release of liability

I, Enter name here, of Enter City here, City of Enter County, State of G\_ EORGIA (Hereinafter the “Releasor”) for and in consideration of: (Check One)

No payment.

Other: Enter text here

THEREFORE under the terms of this Agreement and sufficiency of which is hereby acknowledged, do hereby release and forever discharge The Sobriety Resource, of Marietta, City of Cobb, State of GEORGIA (Hereinafter the “Releasee”) including their agents, employees, successors and assigns, and their respective heirs, personal representatives, affiliates, successors and assigns, and any and all persons, firms or corporations liable or who might be claimed to be liable, whether or not herein named, none of whom admit any liability to the undersigned, but all expressly denying liability, from any and all claims, demands, damages, actions, causes of action or suits of any kind or nature whatsoever, which I now have or may hereafter have, arising out of or in any way relating to any and all injuries and damages of any and every kind, to both person and property, and also any and all injuries and damages that may develop in the future, as a result of or in any way relating to the following:

Any service provided by The Sobriety Resource or its agents.

It is understood and agreed that this Agreement is made and received in full and complete settlement and satisfaction the causes of action, claims and demands mentioned herein; that this Release contains the entire Agreement between the parties; and that the terms of this Agreement are contractual and not merely a recital. Furthermore, this Release shall be binding upon the undersigned, and his respective heirs, executors, administrators, personal representatives, successors, and assigns. This Release shall be subject to and governed by the

laws of the State of GEORGIA,

This Release has been read and fully understood by the undersigned and has been explained to me.

EXECUTED this Enter DAY here day of Enter MONTH here, 20 Enter YEAR here

**RELEASOR’S SIGNATURE:** Enter FULL NAME HERE **DATED**: Enter Date Here

NOTE: By typing and submitting your name in this document, you are certifying that you have read, understand, and agree with the above information as submitted by you to The Sobriety Resource.

# AUTHORIZATION TO RELEASE PERSONAL INFORMATION

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| RESIDENT’S NAME: | X | DOB: | X |  |
| PROGRAM NAME: | X | SSN: | X |  |

I request and authorize ENTER TEXT HERE to release and receive personal healthcare information of the resident named above to:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name: | The Sobriety Resource |  |  |  |  |  |
| Address: | 2681 Ravenoaks Place |  |  |  |  |  |
| City: | Marietta |  | State: | GA | Zip Code: | 30062 |

This request and authorization apply to:

Personal information relating to the following treatment, conditions, or dates: ENTER TEXT HERE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

All Healthcare Information

Other: ENTER TEXT HERE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **Definition:**  **(1)** This record which has been disclosed to you is protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or, is otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder except as provided at §§ 2.12(c)(5) and 2.65; or  **(2)** 42 CFR part 2 prohibits unauthorized disclosure of these records. |  |

I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.  Yes  No

**SIGNATURE:** Enter FULL NAME HERE **DATE**: Enter Date Here

**PRINTED NAME:** Enter FULL NAME HERE **WITNESS:** Enter Text Here

NOTE: By typing and submitting your name in this document, you are certifying that you have read, understand, and agree with the above information as submitted by you to The Sobriety Resource.

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

**APPENDIX A**

**EXAMPLES OF HOMELESS STATUS AND THIRD-PARTY VERIFICATION**

The below information was taken from the “Verification and Certification of Homelessness” provided by the HUD/Emergency Shelter Grant and Georgia Department of Community Affairs (www.dca.ga.gov)

|  |  |
| --- | --- |
| **HOMELESS STATUS /**  **LIVING SITUATION** | **SAMPLE THIRD-PARTY**  **VERIFICATION / DOCUMENTATION** |
| Participant sleeping in place(s) not meant for human habitation | Documentation from neighbors, private citizens, police, DFCS, sheriff, homeless outreach agencies, churches, the address used for public assistance checks, etc. |
| Participant is homeless living in a shelter or in transitional housing | Letter or memo on letterhead from the homeless service agency |
| Participant is within one week of eviction (eviction notification | Eviction notice or a statement describing the reason for eviction. Must be signed and dated. |
| Participant is leaving short-stay facility, such as a detox center, crisis center, jail, etc. (30 days or less) who previously resided on the street, in a shelter, or in a place not meant for human habitation | Letter or memo on letterhead from the short-term facility. Must be signed and dated. |
| Participant is being discharged within the week from institution (jail, mental hospital, personal care home, nursing home, supportive housing program, DFCS, medical facility, etc.) and has been a resident there for more than 30 consecutive days, no subsequent residences have been identified, and without assistance participant would have to sleep in a shelter or in a place not meant for human habitation | Evidence from the institution or a homeless service provider (may be a community mental health agency) that the institution will discharge the participant within 7 days (or has already discharged the participant), that the participant does not have housing resources, that no subsequent residences have been identified, and that the participant lacks the resources and support network needed to obtain housing without assistance |
| Persons fleeing domestic violence | Written verification from the participant that he/she is fleeing a domestic violence situation OR letter from previous domestic violence service provider |