

Parker Gill Foundation Grant Application

Date of Application			
Referral is being made by		Name:	
Position (check one)		<input type="checkbox"/> Case Manager or Counselor	<input type="checkbox"/> Discharge Planner
<input type="checkbox"/> Peer Recovery Specialist		<input type="checkbox"/> Other (Please specify)	
Affiliated Treatment Center or Organization			
<input type="checkbox"/> N/A	Client's First Name:	First Initial, last name	

Type of Support Requested:

<input type="checkbox"/> Gap Treatment Grant			
Treatment Center Client is Entering			
Amount Requested		\$	Date of Admission
Treatment Center Contact		Phone #	
Email Address			
Address			

<input type="checkbox"/> Recovery Housing Grant			
Recovery Housing Client is Entering			
Amount Requested		\$	Date of Admission
Organization Contact		Phone #	
Email Address			
Address To Mail Payment			
Payment Made to			
Is the client motivated to live in a structured, vetted recovery housing organization and willing to follow all treatment facility rules, attend recovery meetings and motivated for a life in recovery?			<input type="checkbox"/> YES <input type="checkbox"/> NO
Is there an after-care plan in place?			<input type="checkbox"/> YES <input type="checkbox"/> NO

<input type="checkbox"/> Recovery Housing Support			
Recovery Housing Organization			
Details of Request			
Amount Requested		\$	
Organization Contact		Phone #	
Email Address			
Address To Mail Payment			
Payment Made to			

<input type="checkbox"/> Recovery food assistance, health assistance, transportation funding, recovery and prevention events or other support			
Requestor Organization or Individual			
Details of Request			
Amount Requested		\$	
Organization Contact		Phone #	
Email Address			
Address To Mail Payment			
Payment Made to			

Please provide a short explanation of the circumstances necessitating the need for funding:

Email completed form to pcunningham@parkergillfoundation.org