WHOLE LIFE HEALING CENTERS, INC.

Scholarship Treatment Fund

Note: This information is confidential and will be used for the sole purpose of tracking demographic information about the people we serve through this program. WLHC does not and shall not discriminate on the basis of race, color, religion (creed), gender, gender expression, age, national origin (ancestry), disability, marital status, or sexual orientation, in any of its activities or operations.

Demographic Information:

Name:	Date:
Age:	Gender: M / F / I do not identify as M or F (circle one)
Phone #:	Is it ok to leave a message for you at this number? Y / N
Mailing Address:	
Email Address:	
How were you referred?	If online, which website?

Patient/Recipient Requirements

Please, indicate below which of the following criteria apply to you:

- ☐ Have been diagnosed with a mental disorder as outlined in the DSM-5, ICD-10, or the PDM-2 by a clinician, or are otherwise psychologically, emotionally, or cognitively vulnerable. Please, indicate diagnosis or explain your circumstances apart from a diagnosis:

  _____

  _____

Have limited access to health care for one or more the following possible reasons:

- ☐ Cannot afford premiums
- ☐ Do not qualify for Medicaid/Medicare
- ☐ Have high deductibles (e.g. greater than $2,500)
- ☐ Do not have mental health coverage

- ☐ Are a veteran of any war or a public servant exposed to trauma (e.g. police officer, paramedic, 911 operator or first responder, etc.)

- ☐ Qualify for ADA (Americans with Disabilities Act) benefits

- ☐ Have an income equal to or less than 125% of the federal poverty level or are otherwise deemed economically vulnerable*

Household Size	Annual Income	Federal Poverty Guideline (FPG)
☐ 1	$12,060	$15,075
☐ 2	$16,240	$20,300
☐ 3	$20,420	$25,525
☐ 4	$24,600	$30,750

*https://www.projusticemn.org/fedpovertyguidelines/

I hereby agree that all information indicated in this document is true to the best of my knowledge and my signature indicates my agreement with receiving Brainspotting services through this grant program. I also agree that I am legally able to give consent for treatment for these services.

Signature: _____ Date:_____