



# The Adam Haslam Foundation

## REQUEST FOR FUNDING

### IDENTIFYING INFORMATION

Name of Individual: \_\_\_\_\_  
 Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Telephone: (\_\_\_\_\_) \_\_\_\_\_ Alternate Phone: (\_\_\_\_\_) \_\_\_\_\_  
 Next of Kin: \_\_\_\_\_ Telephone: (\_\_\_\_\_) \_\_\_\_\_

### EMPLOYMENT INFORMATION

Employer (list work skills if unemployed): \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Telephone: (\_\_\_\_\_) \_\_\_\_\_ Fax Phone: (\_\_\_\_\_) \_\_\_\_\_

### TREATMENT INFORMATION

Current or Prospective Treatment Facility: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Telephone: (\_\_\_\_\_) \_\_\_\_\_ Fax Phone: (\_\_\_\_\_) \_\_\_\_\_  
 Drug(s) of Choice: \_\_\_\_\_ Clean Date: \_\_\_\_\_

### SERVICES REQUESTED

(Check all that apply)

- |  |  |  |  |   |
|--|--|--|--|---|
| <input type="checkbox"/> <b>Medical</b>  | <input type="checkbox"/> <b>Dental</b>       | <input type="checkbox"/> <b>Psychiatric</b>    | <b>Substance Abuse</b>                       | <b>Legal</b>                                  |
| <input type="checkbox"/> <b>Pharmacy</b> | <input type="checkbox"/> <b>Food</b>         | <input type="checkbox"/> <b>Transportation</b> | <input type="checkbox"/> Detox               | <input type="checkbox"/> Civil                |
| <b>Counseling</b>                        | <b>DUI Services</b>                          |  | <input type="checkbox"/> Inpatient           | <input type="checkbox"/> Criminal             |
| <input type="checkbox"/> Individual      | <input type="checkbox"/> Licensed Evaluation |  | <input type="checkbox"/> Outpatient          | <input type="checkbox"/> Family/Child Custody |
| <input type="checkbox"/> Group           | <input type="checkbox"/> Licensed Treatment  |  | <input type="checkbox"/> Residential         | <input type="checkbox"/> Bankruptcy           |
| <input type="checkbox"/> Couples/Marital | <input type="checkbox"/> Driving School      |  | <input type="checkbox"/> Individual          | <input type="checkbox"/> Personal Injury      |
| <input type="checkbox"/> Family          |  |  | <input type="checkbox"/> Group(s)            | <input type="checkbox"/> Corporate            |
| <input type="checkbox"/> Pastoral        |  |  | <input type="checkbox"/> <b>Other:</b> _____ |   |

**SERVICES REQUESTED**

Describe how the funds will be utilized: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Why do you deserve the funding over other applicants? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CRIMINAL JUSTICE INFORMATION**

Current or Most Recent Facility of Incarceration: \_\_\_\_\_

Identification Number: \_\_\_\_\_ Date of Incarceration: \_\_\_\_\_ Date of Release: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: ( \_\_\_\_\_ ) \_\_\_\_\_ Fax Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Parole/Probation Officer: \_\_\_\_\_ County: \_\_\_\_\_

Telephone: ( \_\_\_\_\_ ) \_\_\_\_\_ Fax Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

**MISSION STATEMENT AGREEMENT/RELEASE OF INFORMATION**

I am authorizing H.O.W.Co. – The Adam Haslam Foundation to investigate any statements contained within this application. I further authorize the release of information from any agency in order for H.O.W.Co. – The Adam Haslam Foundation to determine my eligibility to become a recipient for funding by H.O.W.Co. – The Adam Haslam Foundation. I agree to hold harmless any agency which provides information to H.O.W.Co. – The Adam Haslam Foundation which causes H.O.W.Co. – The Adam Haslam Foundation to decline my application for funding. I have read the Mission Statement of H.O.W.Co. – The Adam Haslam Foundation and I/we will honor this statement in regards to my relationship as a client of H.O.W.Co. – The Adam Haslam Foundation.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

Official Use Only – Do not write below this line.

\_\_\_\_\_  
Interviewed By: \_\_\_\_\_ Date: \_\_\_\_\_

Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Approved**       **Unapproved**

Name of Provider: \_\_\_\_\_ Amount: \_\_\_\_\_

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Name of Provider: \_\_\_\_\_ Amount: \_\_\_\_\_

TOTAL: \_\_\_\_\_