Scholarship Treatment Fund Application

The Rocky Mountain Brainspotting Institute (RMBI) is pleased to offer Brainspotting scholarships of up to 10 treatment sessions for qualifying individuals affected by trauma. The Scholarship is meant to be the ***only*** option for accessing treatment. Thus, we have firm restrictions on eligibility.

Please read the following qualification criteria carefully before you apply.

RMBI ACCEPTS SCHOLARSHIP APPLICATIONS FOR INDIVIDUALS WHO:

1. Are uninsured, or whose insurance does not provide mental health coverage;
2. And whose income is less than $2,000 per month but MORE THAN the current Medicaid eligibility requirements.

RMBI does not provide scholarships to anyone who is currently enrolled in Medicaid or whose current monthly income meets the eligibility to enroll in Medicaid. Because there are Brainspotting professionals who accept Medicaid, and there is no limit on the number of sessions available to an enrolled individual, we strongly encourage anyone whose income meets the current Medicaid eligibility to enroll.

Current Medicaid enrollment information can be found at: https://www.healthfirstcolorado.com/

If you are currently enrolled in Medicaid and are looking for a Brainspotting professional please email admin@rockymountainbrainspottinginstitute.com and we will happily refer you.

Please submit your completed scholarship application to:

admin@rockymountainbrainspottinginstitute.com

or mail to 100 Arapahoe Ave Suite 7 Boulder, CO 80302

Scholarships are awarded as funds are available.

Information collected in this application is confidential and will be used for the sole purpose of tracking demographic information about the people we serve through this program. RMBI 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.

1. Demographic Information

Name: _____ Date: _____

Date of Birth: _____ Relationship Status: _____

Age: _____ Race/Ethnicity: _____

# of Dependents: _____ Gender: M / F / I do not identify as M or F

Home/Mobile Phone: _____ Is it ok to leave a message for you at this number? Y / N

Work Phone: _____ Is it ok to leave a message for you at this number? Y / N

Mailing Address: _____

E-mail Address: _____

Current Employer: _____ Position Title: _____

Disabled: Physical Mental or Both

Current Occupational Status: (i.e., F/T, P/T, self-employed, student, returning to work):_____

How long on this Job: _____ Do you enjoy your job? _____

Education Level: _____ Special Trainings: _____

Hobbies: _____ Military Background: _____

Talents: _____

Emergency Contact Name: _____

ER Contact Relationship: _____ Emergency Contact Phone:_____

How were you referred? _____ If online, which website? _____

2. Physical Health Information

Describe your physical health: Excellent ____Good____ Average____Poor____ Weight_____ Height____

Are you now under a doctor's care? _____If yes, name of doctor_____

Reason for doctor's care_____

Hospitalizations and Reasons:

_____

Have you ever been hospitalized for a mental illness?____ Describe_____

Have you even been diagnosed with a mental illness?_____

If you have been diagnosed with a mental illness what is your diagnosis or diagnoses?

_____

Recent major illnesses or surgeries_____

Do you have any current concerns about your physical health? Please specify: _____

Please list medicines you are currently taking, or have taken during the past 6 months (include any medicines that were prescribed or taken over the counter): _____
_____

Do you get regular exercise? Yes__ No__ If so, what type and how often? _____

Please circle any of the following symptoms that apply to you:

Headaches	Stomach trouble	Skin problems	Dizziness
Tics	Dry mouth	Palpitations	Fatigue
Burning or itchy skin	Muscle spasms	Twitches	Chest pains
Tension	Sleep issues	Rapid heartbeat	Tremors
Sexual disturbances	Unable to relax	Fainting spells	Blackouts
Bowel disturbances	Hear things	Excessive sweating	Tingling
Seizures	Visual disturbances	Numbness	Flushes
Hearing problems	Don't like being touched		

3. Family Information

Birthplace: _____

FATHER: age now if living: _____ Age at Death_____ Cause: _____ Your age then: _____

MOTHER: age now if living _____ Age at Death _____Cause: _____ Your age then: _____

Do your parents live together? Yes _____ No_____ Were Parents Divorced? Yes _____No_____

Do you feel closest to your Mother _____Father _____ Both _____ Neither_____

Your Marital Status: _____ #of marriages _____ Spouse's Name_____

Living with a partner _____ How long _____ Partner's Name_____

CHILDREN: #1 M F Age_____ #2 M F Age_____ #3 M F Age_____ #4 M F Age_____ #5 M F Age_____

SIBLINGS: _____Ages_____

Family Alcoholism or Domestic Violence? _____ Sexual Addictions or Abuse? _____

Parents divorced? _____If yes, your age at the time_____ Any step-parents? _____

If yes, describe your relationship with them _____

If raised by someone other than your birth parents, describe:
_____

4. Legal Information

Have you ever been incarcerated (Jail or Prison)? Yes _____No_____ Dates_____

Reason_____Where_____

Have you ever had a DWI (Driving While Intoxicated)? Yes _____ No_____ How Many: _____

Have you ever had a DUI (Driving Under the Influence)? Yes_____ No_____ How Many: _____

Are you currently on Probation? Yes _____ No_____ Explain_____

5. Religious Information

Current Religious Preference or Spiritual Preference if any:

_____

List 3 Support Systems you have in your life right now:

1._____

2._____

3._____

6. Behaviors and Feelings

Circle any of the following behaviors that apply to you:

Overeat	Suicidal attempts	Can't keep a job	Take drugs
Compulsions	Lack of motivation	Aggressive behavior	Smoke
Take too many risks	Odd behavior	Withdrawal	Insomnia
Drink too much	Nervous tics	Eating problems	Work too hard
Procrastination	Sleep disturbance	Impulsive reactions	Crying
Phobic avoidance	Outbursts of temper	Loss of control	Vomiting
Concentration difficulties			

Are there any specific behaviors, actions, habits that you would like to change? _____

Circle any of the following feelings that apply to you:

Angry	Guilty	Unhappy	Annoyed	Happy	Bored
Conflicted	Sad	Restless	Depressed	Regretful	Lonely
Anxious	Hopeless	Contented	Fearful	Hopeful	Excited
Panicky	Helpless	Optimistic	Energetic	Relaxed	Tense
Envious	Jealous	Others:_____			

7. Chemical Dependency Information

Have you ever been in treatment for Chemical Dependency/Addiction? Yes_____ No_____

If Yes, Where: _____ Treatment was for what chemical: _____

Are you involved in a recovery program? Yes _____No_____ Do you attend meetings? Yes ____No ____

Have you completed a 12-step program? Yes ____No _____When _____

Do you have a sponsor? Yes_____ No_____

Have you ever felt you should cut down on your drinking and/or drug use? Yes_____ No_____

Have people annoyed you by criticizing your drinking and/or drug use? Yes_____ No_____

Have you ever felt bad or guilty about your drinking and/or drug use? Yes_____ No_____

Have you ever used alcohol or drugs in the morning to steady your nerves or get rid of a hang-

over? Yes_____ No_____ Have you ever had any drug or alcohol related arrests? Yes_____ No_____

Have you ever had any D.T.'s? (Delirium tremens) Yes_____ No_____ Have you experienced any

blackouts from drugs or alcohol? Yes_____ No_____ Have you ever injected drugs? Yes_____ No_____

8. Treatment History

Have you seen an individual therapist for trauma treatment before? Yes_____ No_____

If so, please describe the type of therapy and approach:

_____

Do you have a psychiatric diagnosis? Yes_____ No _____

If so, what is it and when were you diagnosed? _____

How did you find out about the treatment fund?

_____

Please specifically and clearly Identify one trauma that you would like to work on which you have not worked on before. _____

9. Financial Information

Do you have insurance? Yes _____ No _____

If so, please identify the company and whether or not it covers any portion of psychotherapy.

_____

Do you have access to funds to pay for therapy through Victim Compensation, vocational rehabilitation programs, disability coverage, Worker's Compensation, or auto accident insurance?

Yes_____ No_____ Please specify _____

Please describe your financial need for this program

_____

_____

Please indicate your total ANNUAL household income _____

How many people are in your household? _____