Catholic Charities Day Treatment Program Scholarship Application

Funding Cap: Up to 20% of verified eligible expenses per award period.

Scholarship funds will be applied directly to eligible program expenses and credited to the applicant's Day Treatment Program account and distributed evenly across payments. No cash payments will be issued to applicants. Awards are calculated based on verified financial need and available funding.

A. Applicant Information

Full Name: _____ Date of Birth: _____

If minor: Parent/Guardian Name: _____ Relationship: _____

Address: _____

City/State/ZIP: _____

Phone: _____ Email: _____

B. Program Participation

Day Treatment Program Site: _____

C. Household & Financial Information

Household Size: _____ Monthly Gross Household Income: $_____

Income information is considered part of the decision-making process but is not the sole determining factor.

Income Sources (check all that apply): [] Employment [] Unemployment [] SSI/SSDI [] SNAP [] Other: _____

Affidavit of Income (if needed): I certify the above income is true and complete to the best of my knowledge.

Signature: _____ Date: _____

D. Special Circumstances

Describe any circumstances to show the need for a Scholarship (handwritten or typed and attached). Please limit to 1 page.

E. Consent and Privacy Acknowledgment

I understand that Catholic Charities will collect and use my personal information solely to administer this scholarship, verify eligibility, and follow reporting and audit requirements. My information will be stored securely and accessed only by authorized staff. I consent to the collection and use of the information provided for these purposes. I understand my information will not be publicly shown without my explicit consent.

Signature of Applicant: _____ Date: _____

F. Media Consent

Catholic Charities values the positive impact of our scholarship program and may share success stories to inspire others and prove program effectiveness. By checking the box below, you grant permission for Catholic Charities to use your child's story, first name, and general program experience in promotional materials, reports, or social media. We will never share sensitive details or full identifying information without your explicit consent.

[] Yes, I give permission to share our success story.
[ ] No, I do not give permission.

Signature of Applicant: _____ Date: _____

Applications will be evaluated on a rolling basis by the Program Director and proper staff if funds are available. Applicants will be notified of decisions via mail and telephone.

G. Staff Use Only

Application Received: _____ Reviewed By: _____

Approved Assistance Amount: $_____ Decision Date: _____

Notes: _____