THE FOUNDATION FOR
REDEMPTIVE RELATIONSHIPS

505 Park Avenue North, Suite 212 • Winter Park, FL 32789
Phone: 407-539-0047 • Fax: 407-539-0048

SCHOLARSHIP APPLICATION

In order to provide you with financial assistance for Mental Health Counseling, we will need to evaluate the following information from you. Please fill out this form and mail it to the attention of the Scholarship Committee at the address above.

Name: _____ Date: _____

Address: _____ Suite or Apartment Number: _____

City: _____ State: _____ Zip Code: _____ May We Send Mail Here: ☐ Yes ☐ No

Home Phone: (_____) _____ May We Leave a Message Here: ☐ Yes ☐ No

Mobile Phone: (_____) _____ May We Leave a Message Here: ☐ Yes ☐ No

Work Phone: (_____) _____ Extension: _____ May We Leave a Message Here: ☐ Yes ☐ No

Indicate How Distressing Your Problems Are by Placing an "X" on the Scale Below *(1 = Little Distress; 10 = Extreme Distress)*:

1 2 3 4 5 6 7 8 9 10

Living Situation: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed. Number of Children In Your Care: _____

Income, Savings, and Investments *(Please Indicate Amounts Below, Including Net Salary and Other Forms of Income):*

Monthly Income: $ _____ Savings/Checking: $ _____ Investments: $ _____

Monthly Expenses (*Please Indicate Amount You Spend Monthly on Each Item Below):*

HOUSEHOLD		**TRANSPORTATION**		**RECREATION**	
Rent/Mortgage:	$ _____	Car Payments:	$ _____	Eating Out:	$ _____
Insurance/Taxes:	$ _____	Car Insurance:	$ _____	Entertainment:	$ _____
Utilities:	$ _____	Repairs:	$ _____	Babysitting:	$ _____
Cable Television:	$ _____	Gas:	$ _____	Healthclub Dues:	$ _____
Telephone:	$ _____	Other:	$ _____	Other:	$ _____
Mobile Phone:	$ _____	**CHILDCARE**		**MEDICAL**	
Clothing:	$ _____	Daycare:	$ _____	Health Insurance:	$ _____
Groceries:	$ _____	School:	$ _____	Doctor/Hospital:	$ _____
Credit Cards:	$ _____	Extracurricular:	$ _____	Medications:	$ _____
Other:	$ _____	Other:	$ _____	Other:	$ _____

A: Net Monthly Income: $ _____

B: Total Living Expenses: $ _____ *(Total of All Items Listed Above)*

C: Surplus or Deficit: $ _____ *(Line A Minus Line B)*

Are You Currently in Therapy?: ☐ Yes ☐ No. If Yes, Counselor's Name: _____

By Signing Below, I Acknowledge that the Information Provided Is Both Accurate and Complete.

Signed: _____ Date: _____

FOR OFFICE USE ONLY

A: _____

B: _____

C: _____

Previous Applications:

☐ Denied: ___ / ___ / ___

☐ Approved: ___ / ___ / ___

Number Approved: _____

Scholarship Amount: _____

Current Applications:

☐ Denied: ___ / ___ / ___

☐ Approved: ___ / ___ / ___

Number Approved: _____

Scholarship Amount: _____

Authorization:

Initials: _____

Date: ___ / ___ / ___

Notified: ___ / ___ / ___