



## MHI Application

# Mental Health Initiative Assistance Application

We are thrilled you have found our application for assistance! Please fill out the application form in its entirety. The more detailed and thorough you are, the easier it is for us to be able to provide support. Please allow 7-14 business days for processing of applications. As part of the application process, all applicants who receive grants from MHI will engage in a short interview process prior to awarding a grant to ensure continued interest in treatment and to assess current motivation for treatment. Frequently asked questions regarding our application process can be found at [www.mentalhealthinitiative.info/faq](http://www.mentalhealthinitiative.info/faq) If you have questions that are not answered on the website, feel free to e-mail our team at [director@mentalhealthinitiative.info](mailto:director@mentalhealthinitiative.info) for support, or call us at 615-212-9710.

**Before you get started, are you filling this form out yourself, or on behalf of someone else? \***

**Myself**       **Someone Else**

**If applying on behalf of someone else, please share your information. NOTE: You will be referred to as an "Applicant Supporter" later in this application.**

**If applying on behalf of someone else, do you have their permission to apply? (They will need to sign a release of information later in the application, so having their permission is important!)**

**Yes**       **No**

If the answer above is no, please contact Mental Health Initiative directly before proceeding at 615-212-9710.

## Applicant Information (Information about the person needing support)

**Applicant Name \***

**Phone Number \***

**Email Address \***

**Address \***

**Marital Status \***

Single

Married

Divorced

Separated

Widowed

**Identified Gender \***

**Preferred Pronouns \***

## Applicant Mental Health History

**Are you currently in a mental health hospital or facility? \***

Yes

No

**If yes, please share the name of the facility, the date of admission, and reason for admission:**

Please list all current and past treatment including the type of treatment, facility name, dates of stay, and diagnoses received. Please include any and all past treatment and do not leave anything out. Ex: 1. Inpatient Hospitalization, ABC Hospital, May 1st, 2012-May 4th, 2012, Schizophrenia 2. Inpatient Hospitalization, XYZ Hospital, August 19th 2015-August 25th, 2015, Schizoaffective Disorder 3. Outpatient Therapy, JKL Counseling Services, August 25th, 2015-December 20th, 2020, Schizoaffective Disorder \*

Please describe in narrative form the situation(s) that led you to seek admission to a residential mental health treatment center. Please include anything that will be helpful in determining your level of need and how the financial assistance will improve your well-being and what you hope to accomplish in treatment. \*

## Applicant Financial Information

Do you receive Medicare or Medicaid? \*

Yes

No

Employment Status \*

Full-Time

Part-Time

Unemployed

Self-Employed

Student

Please describe your employment status further in as much detail as possible. Include dates of employment, employer's name, reason for unemployment, student status, and any other relevant information. NOTE: Your employer will not be contacted at any time. This information is simply to understand your financial situation. \*

How many individuals (including you) are in your household? \*

Please include the Name, Age, and Relationship to you for every adult and child in your household. (You must identify all individuals in this section) If more space is needed, please utilize the extra space for additional information at the end of the application.

**Person 1**

Full Name

Age

Relationship

Dependent? (Yes/No)

**Person 2**

Full Name

Age

Relationship

Dependent? (Yes/No)

**Person 3**

Full Name

Age

Relationship

Dependent? (Yes/No)

**Person 4**

Full Name

Age

Relationship

Dependent? (Yes/No)

**Person 5**

Full Name

Age

Relationship

Dependent? (Yes/No)

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**Person 6**

Full Name

Age

Relationship

Dependent? (Yes/No)

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**Person 7**

Full Name

Age

Relationship

Dependent? (Yes/No)

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**Person 8**

Full Name

Age

Relationship

Dependent? (Yes/No)

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**Person 9**

Full Name

Age

Relationship

Dependent? (Yes/No)

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**Person 10**

Full Name

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**What is your monthly household income? \***

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**Monthly Household Expenses: Please identify what your average monthly expenses are below. Do NOT include in this section any personal expenses such as gas, food, or personal hygiene) \***

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**Attach two of the following documents: 1. Most recent tax return, 2. Most recent bank statement, 3. Employment or Unemployment Check Stub, 4. Alternative proof of need documentation or Letter of Explanation \***

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**Upload File \***

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## Applicant Supporter Information

Making the decision to go to residential mental health treatment can be scary and challenging, yet extremely rewarding. It's important to have someone close to you cheering you on and helping you navigate the experience. We ask that you identify 1 individual for Mental Health Initiative to speak to throughout the application process if needed that will be supportive of you during your program stay if MHI is able to award you a grant for treatment. Prior to naming this person, be sure to ask them and confirm they are able and willing to help you through this process. Later in the application, you will see a form titled, Applicant Supporter Release of Information, this form will allow Mental Health Initiative to communicate with your Applicant Supporter.

\*\*If you are unable to find an applicant support individual, please contact Mental Health Initiative for support before continuing at 615-212-9710.

**Applicant Supporter Name \***

First Name

Middle Name

Last Name

**Applicant Supporter Relationship to you \***

Spouse

Brother/Sister

Parent/Step-Parent

Grandparent

Aunt/Uncle

Friend

Guardian/Conservator

Other

**Applicant Supporter Phone \***

**Applicant Supporter Email \***

**Applicant Supporter Address \***

Street Number & Name

City

State

Zipcode

**Is the applicant supporter your legal guardian or conservator? \***

Yes

No

**Final Steps**

**Please identify your level of motivation to fully complete residential treatment. (1 being not motivated at all, 5 being extremely motivated) \***

Motivation for Treatment

1

2

3

4

5

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**Is there anything else you would like Mental Health Initiative to know? This space can also be used for overflow from any questions above. Make sure to specify which question if using this as extra space to write.**

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**If chosen to be a recipient of a Mental Health Initiative grant, can a member of our team contact you to provide a testimonial that shares the impact MHI has had on you? Your answer will NOT affect whether or not you receive aid. \***

Yes

No

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**In order to ensure MHI is able to support individuals who are committed to treatment, we do require our applicants to agree to stay in treatment for the clinically recommended amount of time prior to receiving a treatment grant. If your application is chosen, prior to receiving funds you will be required to sign a document outlining your agreement to completing treatment as recommended by your providers and advising you agree to pay back the grant you received should you leave treatment prematurely against clinical or medical advice, barring any extenuating circumstances. Please indicate below you understand the terms above and wish to continue. If you do not understand and agree, please reach out to our team at [director@mentalhealthinitiative.info](mailto:director@mentalhealthinitiative.info) or 615-212-9710 before proceeding. \***

I understand and agree

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By signing this form, you are attesting that the information provided is true and accurate to the best of your knowledge. Your signature serves as proof of your commitment to honesty and integrity in all aspects of this application.

**Signature \***

Clear Undo

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**Date \***



June



26



2023

