This Whole Life Foundation Scholarship Application

Full Name: ____ Date of Birth: __________________________
Age: ______________ Gender: ____ M ____ F ____ Other Phone: ______________________________
Email: ____
Address: ____

Areas of Concern/reason for needing services:

____

Monthly Income: ____________________ Monthly Bills Expenses: ___________________
(Please note you must provide a W2 or paycheck stub to prove income amount)**

Services you wish to receive: (please check all that apply)
- Mental Health Counseling/Therapy/Wellness Coaching ________
- Healing Intensives (5-hour session) _________
- Nutrition/ Gut Health _______
- Wellness Retreat ________
- Continuing Education/Workshops/Trainings ________
- Other: ____

Insurance Type (write n/a if you have none), insurance ID number, and group number (if applicable):

____

Do you currently have transportation to and from work/appointments? _____ Yes _____ No Do you currently have children or other dependents? _____ Yes _____ No If so, how many? ________ Are you committed to receiving treatment, and pursuing your health/wellness ______ Yes _______ No

If you are a business - Please describe the necessity of wellness services/products/programs within your business, and why you are currently unable to provide these for your employees:

____

____

I certify that all information written above is accurate to the best of my knowledge, and I agree to come forth with any additional information regarding my health care coverage/income as it arises. I also understand that just because an application is submitted to receive these services, does not make me an automatic beneficiary of these funds. I understand that I will be contacted within one week (upon receipt of application) to be made aware of amount of scholarship funds awarded. I also understand that scholarship funds are not endless, and may not always be available. Should this be the case I understand I will be placed on a waitlist to continue further services once funds are received to allow the continuation of those services.

Print Name: ____ Date: ______________________
Signature: ____