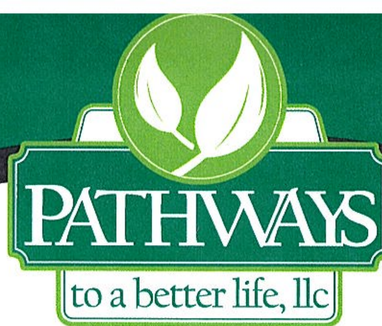


Transitional Residential Treatment Center
13111 Lax Chapel Road | Kiel, WI 53042 | Phone: 920.894.1374 | Fax: 920.894.1373

Scholarship Application

Applicant Information

Name: ______________________________ Phone: ____________________

Address: ____

City, State, Zip: ____

DOB: ________________________ SS#: ____________________________

Contacts

Spouse's Name: ___________________________ Phone: _________________

Add'l Contact/Relationship: __________________________ Phone: ______________

Employer's Name: ______________________________

Do you have health insurance? __________

Insurance Provider Name: ____

Contact Phone: ____________________ Policy Member #: ____________________

Group Name: _______________________ Group #: __________________________

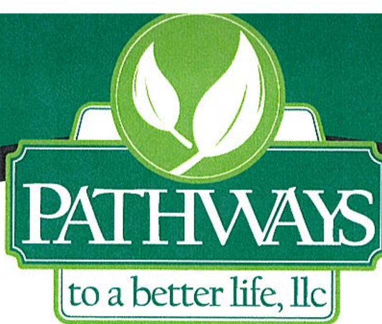
Phone # to call for Authorizations: __________________

Services Being Requested:

- ❑ Sub-acute Detox
- ❑ Residential Treatment
- ❑ Intensive Outpatient (IOP)

Email this form and answers to the following questions to scholarships@pathwaystoabetterlife.com.

1. What is your motivation to seek treatment now?
2. What does a life in recovery look like to you?
3. List two ways you've manipulated loved ones for self-gain.
4. How long have you maintained sobriety without jail or another controlled situation?
5. Are you willing to go into sober living after treatment?
6. Why should you be chosen for this scholarship?



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List All Household Members / Dependents.

Name	Relationship to Applicant	Age

(Total Monthly Household Income must include income for yourself and other household member's Wages, Pension or Retirement Income, Social Security, Unemployment, Worker's Compensation, Alimony and Child Support, and any other income.)

Total Monthly Household Income: $______________

Demographic and History of Client: ______________________________

____

____

History of Abuse: ______________________________

____

____

Drug of Choice: ______________________________

Date and Amount of Last Use: ______________________________

Prior Treatment: ______________________________

____

____

Current Medications: (All medications must be accompanied by a doctor's order.) ______________

____

____

Health Issues: ______________________________

____

____

History of Siezure: ______________________________

Legal Issues: ______________________________

____

Probation Agent/County: ______________________________

Case Worker/County: ______________________________