

**Alcohol, Drug and Mental Health Board
of Franklin County**
Consumer/Family Member Scholarship Application

Please mail this completed, signed application form to the Mental Health Association of Franklin County, 538 E. Town St., Suite D, Columbus, OH 43215 or call 614-221-1441 with any questions.

(Please Print or Type)

Name of person requesting funds:

Home Address:

City:

State:

Zip:

Telephone: Home ()

Work ()

Check payable to (if not yourself):

Organization (if affiliated):

Contact Person of organization you're affiliated with:

Date of Request:

Name of the event (conference, convention, workshop or seminar):

Date of the event:

Location of the event:

Have you received ADAMH funds before? Yes or No (circle one)

If yes, date of last scholarship and amount received:

Are you a consumer or family member? (circle one)

How will you share the information you receive with consumers and/or family members unable to attend this event (i.e., reports, presentation, etc.)?

Total Cost of Event: \$

Travel: \$

Registration: \$

Lodging: \$

Meals: \$

Total Scholarship Amount Requested: \$

Signature of Applicant:

Date:

OFFICE USE ONLY: Amount given: \$

Date:

Check #:

Written report: Y N

Receipts submitted:

Approval: