HOPE Source Grant Assistance Application
Please read the attached HOPE Source Policy in its entirety (separate from this application). This includes important information regarding the requirements for the application. Any incomplete applications will be denied and/or delayed. Applicants can request up to a maximum amount of $1500.00 (not a guaranteed amount) within a 12 month period.

APPLICANT INFORMATION: **D**ate: ____________________________

Provider's Name, License & Phone: ____

Provider's Email: ____

Mailing Address: ____ City & Zip Code: __________________________

Client Name: ____ Amount Requesting: _____________________

Length of time client has been seeing provider: _______________________

Employment status: _______________________ Employer: ____

List ALL sources of income (including spouses/significant other/guardian):____

Does the client have insurance that covers mental health needs? ____

Please use the space below to explain your client's story of need. You may attach additional documentation if necessary.

____
____
____
____
____
____
____
____
____
____

I consent that the information provided is accurate to my knowledge.

Provider's Signature: ____ Date: ________________________

By signing below, I certify that this request has been made voluntarily, that I have read and understand this application and that the information given above is accurate to the best of my knowledge.

Client / Guardian Signature: ____ Date: ___________________________

Please allow 4-6 weeks for review of the application. Be sure to keep a copy of your grant application and all other documentation**.**