



Date: \_\_\_\_\_

FROM: \_\_\_\_\_  
*Name of Applicant – Please Print*

TO: Windhorse Guild Treatment Grant Committee

**Re:** *Treatment Grant Application Forms with Attachments*

Dear Windhorse Guild Treatment Grant Committee:

Attached please find the completed paperwork for the treatment grant application process. I have placed a checkmark (✓) by all completed and attached items.

- Applicant Information Form
- Applicant Financial Information Form for Treatment Grant
- Release of Information Form
- Additional Documents that include: Latest Federal Income Tax Return (with schedules) if completing Financial Information Form 1

Thank you for your consideration of my application.

**Please return all paperwork to:**

**Windhorse Guild, Inc.  
Attn: Treatment Grants Committee  
1501 Yarmouth Avenue  
Boulder, CO 80304**



**WINDHORSE GUILD, INC.**

**Applicant Information Form for Treatment Grants Program**

*Please PRINT Information*

Date of Application: \_\_\_\_\_

Name of Applicant: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Age: \_\_\_\_\_

Street \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Client's Phone # (Cell): \_\_\_\_\_

Client's Phone # (Home): \_\_\_\_\_

Client's E-mail Address: \_\_\_\_\_

**If you are NOT the prospective client, please fill in this next section:**

Referred by: \_\_\_\_\_

Phone # of Referral Source: \_\_\_\_\_

E-mail Address of Referral Source: \_\_\_\_\_

How did you hear about this program? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



**WINDHORSE GUILD, INC.**

**Financial Information Form 1 for Treatment Grant Application**

In order to be considered for a treatment grant through Windhorse Guild, Inc., we ask that you supply us with your most recently filed Federal Income Tax Return (including all schedules), complete this form, and attach any supplemental documentation. Applications without the necessary documentation cannot be considered. Materials should be sent to Windhorse Guild, Inc., attention 'Treatment Grants Committee'. Address: 1501 Yarmouth Avenue, Boulder, CO 80304. All information will be held in strict confidence.

*Please leave blank if not applicable.*

**Other Income (not included on tax return):**

Cash Gifts \_\_\_\_\_  
Family Support \_\_\_\_\_  
Other Support \_\_\_\_\_

**Assets:**

Home (approximate market value) \_\_\_\_\_  
Other real estate \_\_\_\_\_  
Bank account balances -      Checking      =      \_\_\_\_\_  
  Savings      =      \_\_\_\_\_  
  
Other investments \_\_\_\_\_  
Car (s) owned – Blue book value \_\_\_\_\_  
Net worth of business – (submit balance sheet) \_\_\_\_\_  
Other Assets \_\_\_\_\_

**Total Assets:** \_\_\_\_\_

**Expenses:**

Mortgage (s) \_\_\_\_\_  
Auto Loan (s) \_\_\_\_\_  
Other Loan (s) – Please List \_\_\_\_\_  
Other Liabilities \_\_\_\_\_

**Total Expenses:** \_\_\_\_\_

I (We) declare that the information reported on this form is complete and correct to the best of my (our) knowledge.

\_\_\_\_\_  
Name of Applicant – Please Print

\_\_\_\_\_  
Name of Person Completing Form (print)

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\*Attachments: Make sure to attach your most recently filed Federal Tax Return, and schedules. Please include any additional information or exceptional circumstances that you think committee should be aware of.

\*\*Worthy of Note: Applicant understands that applying for a treatment grant in no way guarantees that a grant will be awarded.



**WINDHORSE GUILD, INC.**

**Financial Information Form 2 for Treatment Grant Application**

In order to be considered for a treatment grant through Windhorse Guild, Inc., we ask that you supply us with the following financial information. Complete this form, and send with the other application materials to: Windhorse Guild, Inc., attention 'Treatment Grants Committee'. Address: 1501 Yarmouth Avenue, Boulder, CO 80304. All information will be held in strict confidence.

*Please leave blank if not applicable.*

**Income from:**

SSI	_____
SSDI	_____
Other Support	_____

**Assets:**

Bank Accounts:			
	Checking	=	_____
	Savings	=	_____

Other: *(please list)*

_____	_____
_____	_____

**Expenses:**

Auto Loan	_____
Other Loan(s)	_____
Other: _____	_____

I (We) declare that the information reported on this form is complete and correct to the best of my (our) knowledge.

\_\_\_\_\_  
Name of Applicant – Please Print

\_\_\_\_\_  
Name of Person Completing Form (print)

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

*\*\*Worthy of Note: Applicant understands that applying for a treatment grant in no way guarantees that a grant will be awarded.*



## Authorization for Release of Information

Client's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I, \_\_\_\_\_, authorize Windhorse Guild, Inc. to use or  
(Patient/legal representative)

disclose to (and obtain \_\_\_\_\_  
additional information from): \_\_\_\_\_  
(Name and Address of person/entity to whom disclosure will be made)

the following protected health information: \_\_\_\_\_  
\_\_\_\_\_.

The purpose of the use or disclosure is: \_\_\_\_\_.

I understand that information disclosed pursuant to this authorization may include information relating to sexually transmitted disease, AIDS/HIV, treatment for alcohol and drug abuse, and psychological or psychiatric conditions unless restricted as follows: \_\_\_\_\_  
\_\_\_\_\_.

Once information is disclosed pursuant to this signed authorization, I understand that the federal privacy law (45 C.F.R. parts 160 and 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit recipient from redisclosing it, except for information related to drug and alcohol treatment, which is protected by federal law from re-disclosure.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. I understand that my revocation must be in writing. In any event, if not revoked earlier, this authorization expires automatically upon \_\_\_\_\_.

I understand that I may refuse to sign this authorization. We cannot condition treatment on an authorization unless you are (1) seeking health care services from us solely for the purpose of creating protected health information for disclosure to a third party or (2) seeking research-related treatment. If either of these circumstances applies, we will not provide the requested treatment if you refuse to sign this authorization. I hereby release the above parties from any liability resulting from the release of this information. A copy of this authorization may be used with the same effectiveness as the original.

Signature of patient: \_\_\_\_\_ Date: \_\_\_\_\_  
Please print name: \_\_\_\_\_

Signature of Representative (if required): \_\_\_\_\_  
Please print name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

"This information has been disclosed to you from records protected by Federal confidentiality rules. 42 CFR, Part II. The Federal rules prohibit you from making further disclosure of this information unless further disclosure is expressly permitted by the 42 CFR, Part II. A general authorization for the release of medical or other information is NOT expressly permitted by the 42 CFR Part II. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patient."