# 2019 Raymond Rountree Jr. Memorial Treatment and Recovery Scholarship*

**Purpose:**
This scholarship was established in memory of Raymond Rountree Jr. to benefit drug and opioid addiction patients and survivors, so they can realize their potential and fulfill addiction-free lifestyle dreams.

**Award:**
One (1) need-based merit scholarship will be awarded to provide financial assistance to an eligible recovery candidate who will participate in a 12-week IOP program at a Mile High Continuing Care designated facility. Economic and culturally diverse applications are encouraged, especially from candidates of under-represented minority populations.

**Eligibility:**
Applicant must be drug and opioid addiction patients/survivors who are graduating or have completed a Partial Hospitalization Program (PHP), Short Term Intensive Residential Remediation (STIRRT) Treatment program accredited and joint commission licensed in State of Colorado or an equivalent type program for out of state applicants.

The RRJr Foundation scholarship is open only to those legal residents of the fifty (50) United States who are eighteen (18) years of age or older at the time of application and planning to enroll in a 12-week Intensive Outpatient Treatment Program in the current calendar year, at the Mile High Continuing Care in Denver, CO. Current employees, officers, directors and agents of both the RRJr Foundation and Mile High Continuing Care, its related companies and members of their immediate families (defined as spouse, parents, siblings and children) and persons affiliated to either entity are not eligible to win.

**Selection Criteria and Process:**
The Raymond Rountree Jr. Memorial Treatment and Recovery Scholarship Selection Committee will select recipients based on their commitment to personal recovery, educational goals, current financial need, references, and response to the essay questions within the application. *Please note that some requirements may change.

**Application Requirements:**

- Completed & Signed Application (online, emailed or mailed)
- Up to three (3) Letters of Reference (one must be from a treatment/therapeutic counselor)

Correspondence and questions should always be addressed to the “RRJr Foundation Scholarship Committee”. In the subject of email submissions include: RRJr Foundation Scholarship Application. Once completed, please submit all information to the RRJr Foundation Scholarship Committee as follows:

By Email: info@sosrrjrfoundation.org

By Mail: RRJr Foundation Scholarship Committee
PO. Box 441101
Aurora CO 80044
720.354.7940

**REMINDER:**

**The deadline for this application to be received by the Foundation’s Office is:**

**DECEMBER 31, 2019**

## Raymond Rountree Jr. Memorial Treatment and Recovery
### SCHOLARSHIP APPLICATION 2019

When filling out this application please note all information is valued as confidential and an applicant, upon signing this application, releases the right to the RRJr Foundation to share or communicate medical therapy health act information with designated consent providers to verify applicants' eligibility to qualify for the IOP scholarship. We recognize your right to privacy and include consent through a HIPPAA Privacy Authorization*** Form attached to your application.

*Thank you in advance for allowing us to help uplift you in your journey with verifying information as necessary to award this opportunity to help another in need.*

| Please **type** or **legibly print** all parts of the application. | | |
|---|---|---|
| 1. | Last Name: | First Name: MI: |
| 2. | Mailing Address<br>Street City: State: Zip: | |
| 3. | Daytime Telephone Number: ( ) Cell Phone: ( )<br><br>Email Address: | |
| 4. | Date of Birth: Month Day Year Gender: | |
| 5. | Emergency Contact: Phone Number: ( )<br>Relationship to Patient: | |
| 6. | List Gross Annual Income from your 2017 Income Tax Form 1040(Line #22), 1040EZ (Line #4), or 1040-A (Line #15): $<br><br>*(If selected, recipient may be asked to verify annual household income by supplying pg. 1 of their 2017 IRS Income Tax Form and any additional financial support requested by IOP sponsor)* | |
| 7. | Insurance Coverage<br>Insurance Company: Member/Policy ID #: Group #:<br><br>Provider Eligibility Phone # (usually on back of card): | |
| 8. | Are you the first person in your family to go through therapeutic counseling and/or rehabilitation treatment in relation to drug or alcohol abuse/addiction: YES ___ NO ____ How long has it been:_______________ | |
| 9. | Is your current treatment facility referring you to an IOP type program? Yes_________ No__________<br><br>Type of Program Suggested/Currently Enrolled: ____________________________________<br><br>If your answer is 'yes' please answer blocks A, B, C below. If your answer is 'no' go to item 11.) | |
| 10. | A. Referring Counselor and /or Physician his/her full name: | |
| | B. Name of Facility: | C. Phone Number: |

**Additional Treatment History**

| Name & Treatment Facility | Name & Title of Primary Contact | City/State | Dates Attended | Completed? |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**EDUCATION (List in order, beginning with the most recent)**
Schools Previously Attended:

| High School, Colleges & Universities | City/State | Dates Attended | Degree Earned (if any) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**EMPLOYMENT (Attach resume or additional sheet if necessary)**
Please list your employment history, starting with your most recent job you have held

| Name of Employer | City/State | Dates of Employment | Type of Work | Hours worked per week |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**(If your resume answers Education & Employment, please attach and skip to Community Service question)**

**COMMUNITY SERVICE (Attach additional sheet if necessary)**
List volunteer work or community service you performed without pay starting with the most recent. Please list approximate total hours of work/service, not average hours per week.

| Name of Organization | Dates of Participation | Type of Work/Service | Total Hours of Work/Service |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**EXTRACURRICULAR ACTIVITY (Attach additional sheet if necessary)**
List your extracurricular activities involvement, starting with the most recent.

| Activity | Dates of Participation | Specify Leadership Position Held |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**REFERENCES**

**Please attach (upload) up to three (3) letters of recommendation from** unrelated persons as character references who know you through school, church/faith-based involvement, community involvement or employment**.** One must be from a counselor or treatment related activities. *Indicate if reference prefers phone verification over letter upload.*

| Reference Full Name | Position/Title | Organization & Location | Phone Number | No. Yrs Known |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**FINANCIAL NEED STATEMENT (Attach separate sheet)**
Please briefly describe your financial need circumstances and how you would benefit from this scholarship. You are also encouraged to attach any relative documentation as additional support of your need (e.g. most recent tax returns, W2 forms, bank statements, etc.)

Note that upon selection, the scholarship recipient may be asked to verify annual household income by supplying pg. 1 of their 2017 IRS Income Tax Form and any additional financial support requested by IOP sponsor.

**ESSAY QUESTIONS**

1) What has prompted you to submit consideration for this scholarship?
2) What have you done for your recovery up to this point?
3) How will this scholarship help you?
4) What recovery milestones must you still achieve?
5) How will you “pay this gift forward?”

**Application Check List:**

- ☐ Completed & Signed Application (online, emailed or mailed)
- ☐ Up to three (3) Letters of Reference (one must be from a treatment/therapeutic counselor)

**MAIL COMPLETE APPLICATION PACKAGE TO THE FOUNDATION AT:**

**Foundation Scholarship Committee**
**c/o Raymond Rountree Jr Foundation, Inc.**

P.O. Box 441101
Aurora CO 80044

By Email: info@sosrrjrfoundation.org

Inquiries: 720.354.7940

**REMINDER:**

**The deadline for this application to be received by the Foundation’s Office is:**

**DECEMBER 31, 2019 NO EXCEPTIONS!**

**STATEMENT OF ACCURACY & APPLICANT CERTIFICATION**

I hereby affirm and certify that all the above stated information provided by me is true and correct to the best of my knowledge. I also consent that if chosen as a scholarship awardee, my picture may be taken and used to promote the Foundation's scholarship program. (Awardee may waive photo due to unusual or compelling circumstances.)

I hereby understand that if chosen as a scholarship awardee, according to the RRJr Foundation Scholarship policy, I must abide to the following stipulations:

- Be present at any potential awards ceremony, events, and/or including any acknowledgment events
- Remit to the Foundation the appropriate information for my scholarship to be paid directly to my therapeutic institution (in this event Mile High Continuing Care Recovery and Treatment Center) for my enrollment in an Intensive Outpatient Program (IOP)
- I hereby understand I will not submit this application without all required attachments and supporting information. Incomplete applications or applications that do not meet eligibility criteria will not be considered for this scholarship.
- I understand that misrepresentation in any statement may be considered reason for disqualification and/or repayment of any scholarship. If I am awarded a scholarship, I agree to abide by all requirements and responsibilities of the award.

Applicant's Signature: _______(e-sIGN)__________________________Date: _____/_____/______

Printed Applicant Name: _________________________________________________________

**STATEMENT OF SUPPORT BY COUNSELOR**

I hereby affirm that this application meets the criteria set forth by this scholarship program and that I support this application to RRJr Foundation. I understand all application awards are pending Mile High Continuing Care's admissions final approval.

Name of Counselor/Faith Based representative submitting the application: ________________________________

Organization: ______________________________________________________________________________

Contact information (email and phone):____________________________________________________________

**Signature of Referral:** ____________________________________ **Date:** _________________

____________________________________

Applicant's Full Name