# CONFIDENTIAL M. Patricia Carroll Fund Application

First Name: ____________________ Last Name: ______________________________________

Applicant type: Lawyer_____ Judge _____ Law Student _____

Your Contact Information:_________________________________________________________

Proposed Treatment Provider (Name & Contact Information):

________________________________________________________________________________

________________________________________________________________________________

Diagnosis and the treatment recommendations, if applicable:

________________________________________________________________________________

________________________________________________________________________________

Have you been in treatment for this illness before. If so, please briefly describe your recent history:

________________________________________________________________________________

________________________________________________________________________________

Proposed Cost of treatment (per session/for length of stay): ______________________________

________________________________________________________________________________

If you are requesting assistance for an inpatient treatment facility, have you inquired about a scholarship? __________ Result? _____________________________________________

________________________________________________________________________________

Do you have healthcare coverage? If so, what amount will your insurance company cover. If you are uninsured, have you pursued Medicaid or county assistance?

________________________________________________________________________________

________________________________________________________________________________

Amount you and/or your family can contribute, if any: __________________________________

________________________________________________________________________________

Total Amount requested: __________________________________________________________

Have you received funds through MPCF in the past? _______ When, and how much was provided: _______________________________________________________________________

Please briefly explain the circumstances surrounding your need(s) for assistance and/or ways in which the MPCF might help (attach another page if you need more space):

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Are you willing to participate in a Lawyers 12 Step or Mental Health Recovery Meeting? ______

Are you willing to request a PALCL Volunteer? ________________________________________

**MPCF is NOT a Healthcare Provider. However, your request for assistance from The MPCF will be treated as confidential and will not be shared with anyone other than your provider, any designee, or as may be necessary under applicable law. As a condition for receiving assistance, you agree to allow a representative of MPFC to speak with your treatment provider solely for the purpose of confirming your continued compliance with your treatment.**

________________ ________________________________

Date: Signature