



## HUGS Foundation Application

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

**Please note: The HUGS Mission is to support FAMILIES in recovery. Applications will only be considered when the family meets these two key criteria:**

- ✓ Parent/family recovery participation (in family treatment services, in support groups)
- ✓ A specific plan to "Pay It Forward"

**Each application **MUST** be filled out completely by a licensed clinician and include:**

- ✓ Client's age (13-24)
- ✓ Completed by a licensed clinician\* (licensed to diagnose and treat substance use disorders) who is familiar with the client and family
- ✓ Information about treatment program, including Referring Clinician's name, license number, phone, fax and email
- ✓ Instructions for disbursement of funds. If request is for more than one month, an update on client's and family's progress must be received before check will be sent
- ✓ Information about client and family must be case specific

**All applications must be submitted through the HUGS website portal at: [hugs@hugs4families.org](mailto:hugs@hugs4families.org) and include:**

- ✓ Fully completed application, including client and family situation
- ✓ Signed Release authorizing HUGS to release information
- ✓ A separate letter from parents to be completed and submitted online with application

*\* \* Application will not be reviewed unless all three documents above are received \* \**

***\* It is the responsibility of the Referring Clinician to verify the legitimacy of the sober living facility or treatment program***

HUGS is committed to bringing recovery to families in Northeastern Ohio. Our goal is to help as many families as possible each year defray the cost of residential treatment and extended care for their chemically dependent young person. Recovery from addiction gives the addict and their family **HOPE** for the future; **UNDERSTANDING** of where they have been and where they want to go; **GRATITUDE** for those who have helped them and **SERENITY** to enjoy life and the person that they were meant to be. HUGS are meant to be given as well as received. It is very important to us that parents & families who receive funds from HUGS are willing to find a personal means of reaching out to others still in need of addiction recovery.

**REQUIRED ----> \_\_\_\_\_ I have read and understand the HUGS Mission above**



## HUGS Foundation Application

FOR OFFICE USE ONLY:

Date Received: \_\_\_\_\_ Action: \_\_\_\_\_ Amount of Money: \_\_\_\_\_

### Referring Clinician Information:

Referring Clinician: \_\_\_\_\_

Valid License Number & Credentials: \_\_\_\_\_ (choose one): \_\_\_ M.D.

\_\_\_ Psychologist \_\_\_ Addiction Counselor \_\_\_ Social Worker \_\_\_ Professional Counselor

Describe your clinical role with family: \_\_\_\_\_

Agency: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Office \_\_\_ Mobile \_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Client's Name: \_\_\_\_\_ Age: \_\_\_\_\_

### Parental/Caregiver Information:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Home \_\_\_ Mobile \_\_\_ Work \_\_\_

Email: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

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

Phone: \_\_\_\_\_ Home \_\_\_ Mobile \_\_\_ Work \_\_\_

Email: \_\_\_\_\_

Amount Requested: \$ \_\_\_\_\_ Number of Months: \_\_\_\_\_  
Purpose: \_\_\_ Treatment \_\_\_ Room and Board \_\_\_ Other \_\_\_\_\_

### Where will the funds need to be sent?

Name: \_\_\_\_\_

Address: \_\_\_\_\_

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



## Family Support Information:

**1. Residence:**

Prior to treatment (or currently), where does the client reside?

**2. Parental Financial Support:**

*If the young person is over 18 years old, please detail family's financial support).*

Is the young person dependent upon family financially for housing? (explain)

Any other expenses related to young person becoming independent (*i.e., schooling, medical needs*)?

Who provides insurance coverage, if any? (describe coverage)

**3. Family Recovery Behaviors:**

Is the family participating in the client's treatment?

NO (**STOP HERE – CANNOT CONTINUE WITH HUGS APPLICATION**)

YES (describe in detail)

Do family members participate in community support groups?

NO (**STOP HERE – CANNOT CONTINUE WITH HUGS APPLICATION**)

YES (select all that apply)

AL\_ANON

FAMILIES ANONYMOUS

NAR-ANON

CELEBRATE RECOVERY

OTHER

Please detail your support group involvement. How long have you been attending? How often? Which meetings do you attend?

Does this family demonstrate behaviors consistent with positive family support for addiction recovery? (describe in detail)





### Client Information (con't)

What else would you like the HUGS Foundation to know about this young person and family?

### Facility/Program Recommended for Client:

Please include verifying information about the facility (*i.e. a brochure, a website, a contact name and phone number. The facility must be licensed/credentialed*).

Website Address \_\_\_\_\_

Contact Name \_\_\_\_\_

Phone Number \_\_\_\_\_ Office \_\_\_ Mobile

What specific costs would assist the family?

Once complete, please save this Application to your desktop, and email it to:

[hugs@hugs4families.org](mailto:hugs@hugs4families.org)