CHANGE YOUR BRAIN CHANGE YOUR LIFE FOUNDATION

APPLICATION FOR ASSISTANCE

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1. OVERVIEW

Congratulations on taking the first step toward a better brain which will result in a better life! The foundation awards free and reduced cost Amen Clinics evaluations and BrainMD supplements to individuals in need, military and first responders. The Change Your Brain Change Your Life Foundation is a nonprofit organization dedicated to providing innovative Amen Clinics Method mental/brain health services to individuals who cannot afford it. Individuals in need of care are encouraged to complete the following application, and if selected, agree to complete a formal online intake form to determine if they are truly ready for help, whether they have any other means of assistance, and if the Amen Clinics Method would be beneficial. Those approved for Amen Clinics services and BrainMD supplements will be sent to the location closest to their primary residence.

OUR PURPOSE is threefold: 1) Fund research that demonstrates improved mental health outcomes by using neuroimaging to inform diagnosis and treatment, 2) Support those in need who cannot afford assessment and treatment, and 3) Educate, especially our children, on how brain health is central to all health and success.

OUR VISION: Founded by Daniel G. Amen, MD in 2008, the Change Your Brain Change Your Life Foundation is dedicated to brain imaging research to change how psychiatric medicine is practiced; Amen Clinics Method services for people who cannot afford them and brain health education for all. Based on his 30 years using brain imaging tools, Dr. Amen knows you are not stuck with the brain you have, you can make it better, which drives the day-to-day work of our foundation.

2. CHANGE YOUR BRAIN CHANGE YOUR LIFE GUIDELINES

Please read carefully and initial before completing and submitting this Application.

Initials:

- Funding assistance is for low income individuals / military / and first responders.
- Proof of income, medical history, military ID, first responder ID, and financial documents will be required to receive assistance.
- The purpose of this application is to determine the need for financial assistance and treatment, as well as the appropriateness of an Amen Clinics Evaluation.
- If approved, payment will be made directly to Amen Clinics, Inc.
- Requests will receive a response within 3 weeks from the receipt of completed application. Approval may take up to 90 days. (Incomplete applications will be returned to the applicant.)
- A potential recipient must first go to family members and/or apply for Care Credit (https://www.carecredit.com/) for assistance before he/she will be considered for Change Your Brain Change Your Life Foundation assistance. (If a potential recipient will not go to family members and/or apply for Care Credit for financial support, there must be an adequate reason.)
- Potential recipients must be willing to make the necessary arrangements to attend all physical and virtual appointments included in the Amen Clinics evaluation and included follow-up appointments. Failure to commit to the scheduled appointment times may result in the cancellation of continued funding for services.
- The Change Your Brain Change Your Life foundation and/or the Award Review Team has the right to refuse assistance to anyone.
- If, for any of the above reasons, an individual does not qualify for treatment and/or financial assistance for services, members of the Change Your Brain Change Your Life Foundation and/or the Award Review Team may guide the individual towards other appropriate organizations for assistance.

I, the undersigned, have read and agree with the Change Your Brain Change Your Life Foundation's application guidelines before completing this application. I also understand that the Foundation and the Award Review Team will hold all information in the utmost of confidentiality.

_____	_____
Signature of applicant, or Parent/Guardian if for a minor	Signature of Spouse if married
_____	_____
Printed Name	Printed Name
_____	_____
Date	Date

Please return completed application via:

MAIL: Change Your Brain Change Your Life Foundation, Inc.
Attention: Tanya Curtis, Foundation Director | 3150 Bristol Street, Suite 400 | Costa Mesa, CA 92626

EMAIL: Tanya Curtis, Foundation Director | tcurtis@changeyourbrain.org

CHANGE YOUR BRAIN CHANGE YOUR LIFE FOUNDATION APPLICATION

For Office Use Only
Received Date ___/___/___ Date Applicant Contacted ___/___/___ Approved by _____

Please attempt to answer all questions on this form. We realize that many of these questions are of a personal nature, however, the more specific the information, the easier it is for us to evaluate your situation.

3. PERSONAL INFORMATION

Male ____ Female ____

_____ _____
Last Name, First Name, Middle Initial Date

_____ _____
Street Address Years at address

_____ _____ _____
City State Zip Code

_____ _____/_____/_____ _____
Social Security Number Birth Date Age

_____ _____
Home or Cell Phone (circle) Email Address

The following information is required for grant purposes.
How many in household? _____ Female head of household? Yes ____ No ____ Disabled? Yes ___ No ____
Ethnicity/Race (check one) ____ Hispanic, or Latino, of any race ____ Native Hawaiian or Pacific Islander, not Hispanic or Latino ____ Asian, not Hispanic or Latino ____ American Indian or Alaska Native, not Hispanic or Latino ____ Multiracial, not Hispanic or Latino ____ Black or African American, not Hispanic or Latino
____White, not Hispanic or Latino

EDUCATION

_____ _____
Last school attended Degree/ Certificate
Did you graduate? Yes ____ No _____ Year graduated: _____

_____
Other trade/business schools or certificates

4. COUNSELING HISTORY

(If additional space is needed for any question, please write "see attached" and provide attachment(s). Please include the question with your answer.

Have you ever been treated for a mental health issue or substance abuse? Yes ____ No ____
If yes, what dates did you receive treatment? _____ _____
Treatment start date Treatment end date
Were you given financial assistance? Yes ____ No _____
If yes, how much assistance did you receive and who provided financial assistance? _____
_____

If no, how did you pay for treatment? _____
_____

Are you currently working with a counselor, therapist, psychiatrist, and/or physician? Yes ____ No ____
If yes, please provide the name(s) and title(s) of all that apply:
_____

Are you in a support group? Yes ____ No ____
If yes, please provide name/type of group and leader name:
_____

Are you also seeking mental health care from other institutions or nonprofit organizations? Yes ____ No ____
If yes, please provide names of other institution(s) or nonprofit organization(s):
_____

Do you have health insurance? Yes ____ No ____
If yes, please provide name of insurance provider and your co-pay for mental health services:
_____

Are you currently in an inpatient or outpatient program? Yes ____ No ____
If yes, please provide details including the type of program and name of the program/facility:
_____

Are you taking medication(s)? Yes ____ No ____
If yes, please provide name of medication(s) and let us know how long you have been taking this/these medication(s):
_____

Briefly describe your current situation: _____
_____
_____
_____
_____

What events prompted you to seek assistance from the Change Your Brain Change Your Life Foundation?
_____
_____
_____
_____

Have you previously applied for Change Your Brain Change Your Life Foundation assistance? Yes ____ No ____
If yes, please provide details:
_____

Have you made a request for financial assistance from any other party/group or nonprofit? Yes ____ No ____
If yes, please specify date(s), organization(s) and amount(s):

_____

_____

How were you referred to Change Your Brain Change Your Life Foundation?
Name: _____ Phone #: _____
Social Media _____ Email _____ Website_____ Other_____

5. FAMILY

Marital Status: Single ____ Engaged ____ Married ____ Separated ____ Divorced ____ Widowed ____

_____ _____ Male ____ Female ____

If married, Spouse's Name Spouse's Age

_____

If married, Spouse's Phone # and Email Address

Dependent's names and ages:

Male ____ Female ____ Birthdate: _____ Age: _____ Lives with Applicant? Yes ____ No ____
Male ____ Female ____ Birthdate: _____ Age: _____ Lives with Applicant? Yes ____ No ____
Male ____ Female ____ Birthdate: _____ Age: _____ Lives with Applicant? Yes ____ No ____
Male ____ Female ____ Birthdate: _____ Age: _____ Lives with Applicant? Yes ____ No ____
Male ____ Female ____ Birthdate: _____ Age: _____ Lives with Applicant? Yes ____ No ____

Does your family of origin have the means to help you? Yes ____ No ____

If yes, have you contacted your family members regarding your need? Yes ____ No ____
(Please refer to the 6th bullet of the Foundation Application guidelines in bold, on page 1)

If you have contacted your family member(s), are they able/willing to help? Yes ____ No ____

If no, please explain why.

_____

_____

_____

6. EMERGENCY CONTACTS

Please list two individuals who can be notified in the event of an emergency.

_____ _____
Name of Emergency Contact Relationship to Applicant

_____ _____
Phone # of Emergency Contact Email of Emergency Contact

_____ _____
Name of Emergency Contact Relationship to Applicant

_____ _____
Phone # of Emergency Contact Email of Emergency Contact

7. EMPLOYMENT HISTORY

(If you have a resume, please attach for reference)

_____ _____ _____

Current Employer From To

Week Month Annual

_____ _____

Position/Title Pay Amount Circle one above

_____ _____

Current Employer Address Current Employer Phone #

_____ _____ _____

Previous Employer From To

Week Month Annual

_____ _____

Position/Title Pay Amount Circle one above

_____ _____

Previous Employer Address Previous Employer Phone #

_____

Reason for Termination

8. FINANCIAL INFORMATION

(Please fill in all information that applies to you. Write N/A if it does not apply.)

Are you currently in the military or are you a veteran? Yes ____ No ____ If yes, please skip to Section 9.

Gross Monthly Income

Source	Amount	Source	Amount
Employment Income		Social Assistance (Medi-Cal or other)	
Spouse Income		Rental Income	
Overtime Bonus, Commission		Other (Alimony, Child Support, etc.)	

Assets

Type	Value	Details (Name of Bank or Ins., Property Type, etc.)
Checking Account(s) Total		
Savings Account(s) Total		
Credit Union Total		
Trust Funds/Stocks/Bonds		
401K/IRA		
Life Insurance		
Property/Home Value		
Automobile #1		
Automobile #2		
Automobile #3		
Personal Property		
Cash on Hand		
Other		
Other		

Monthly Expenses (Please be specific as possible)

Type	Name of Debtor	Monthly Payment	Balance Owed	Interest Rate
Rent/Mortgage				%
Auto Loan				%
Personal Loan				%
School Loan				%
Utility: Gas				%
Utility: Electric				%
Utility: Land Line				%
Utility: Cable				%
Utility: Internet				%
Utility: Water				%
Utility: Trash				%
Taxes/IRS Debt				%
Credit Card				%
Credit Card				%
Credit Card				%
Credit Card				%
2nd Auto Loan				%
3rd Auto Loan				%
2nd Property Loan				%
Other				%
Other				%
Other				%
Other				%
Other				%
Other				%

Please list other sources of assistance that you have sought (parents, family, loans, sale of personal property, social programs).

_____

_____

_____

_____

Are you willing to share all your financial details (in confidence) with a Change Your Brain Change Your Life Foundation representative? Yes ____ No ____

9. AGREEMENT

MY (OUR) AGREEMENT WITH CHANGE YOUR BRAIN CHANGE YOUR LIFE FOUNDATION

I (we) have read and understand the Change Your Brain Change Your Life Foundation application guidelines. I (we) am (are) willing, to accept financial assistance towards an Amen Clinics evaluation as a gift and understand that repayment is neither necessary nor expected. I (we) understand that the Award Review Team may verify any information as part of determining whether or not Change Your Brain Change Your Life Foundation will provide services. I (we) understand that Change Your Brain Change Your Life Foundation Award Review Team and/or volunteers will attempt to assist me (us) in scheduling appointments, if approved, and that they do not make any representations or warranties with respect to the results of an

Amen Clinics Evaluation or BrainMD supplements or their ability to help me (us) with my (our) needs. I (we) further agree to indemnify and hold harmless all staff and/or volunteers of Change Your Brain Change Your Life Foundation or Amen Clinics, Inc. and its employees, agents, doctors, counselors, consultants, officers, and directors from any claim, suit, action, demand, or liability of any kind and any nature arising out of or in any manner connected with my (our) participation in these services. I (we) hereby certify that the answers and other information on this application are true and correct and that I (we) understand any misrepresentation or omission of facts on my (our) part will disqualify me (us) from this service.

_____	_____
Signature of applicant, or Parent/Guardian if for a minor	Signature of Spouse if married
_____	_____
Printed Name	Printed Name
_____	_____
Date	Date