

# Application for Counseling Grant



Behind the Scenes is a 501(c)(3) charitable organization which provides to qualified Eligible Persons financial assistance for mental health counseling and treatment of chemical dependency. Grants are issued directly to the recipient's self-selected provider, which must be a licensed social worker, psychotherapist, psychiatrist, mental health facility, emergency medical facility, or chemical dependency recovery facility.

An Eligible Person is an individual who currently resides in the United States or Canada and has earned their living for a minimum of five years in the entertainment technology industry. An eligible person does not need to be currently working in the industry as long as the time out of the industry is less than the total time worked in the industry. Performing artists are not eligible. Final determination of eligibility is at the sole discretion of the Board of Directors of the Behind the Scenes Foundation.

Applications can be submitted on behalf of an Eligible Person by a legal guardian or a person acting pursuant to a valid power of attorney or under other legal authority. Applications may also be submitted on behalf of an eligible grantee by an individual acting in the best interests of the grantee regardless of legal status if no one of legal status is capable of acting or available to act on the grantee's behalf. Applications must be completed in full. The information contained in this Application will be held confidential unless otherwise required by law.

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

Name of Eligible Person: \_\_\_\_\_

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

City: \_\_\_\_\_ State/Province: \_\_\_\_\_

Zip/Postal Code: \_\_\_\_\_ Country: \_\_\_\_\_

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

Cell: \_\_\_\_\_ Fax: \_\_\_\_\_

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

*If you are applying on behalf of an Eligible Person, please complete the information below:*

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

Relationship to Eligible Person (*you may be asked to provide documentation of relationship such as marriage certificate, birth certificate, proof of joint assets or joint obligations, proof of guardianship or power of attorney*):

Spouse  Domestic Partner  Child  Legal Guardian  Power of Attorney  Other \_\_\_\_\_

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

City: \_\_\_\_\_ State/Province: \_\_\_\_\_

Zip/Postal Code: \_\_\_\_\_ Country: \_\_\_\_\_

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

Cell: \_\_\_\_\_ Fax: \_\_\_\_\_

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

**Information on Eligible Person**

Eligible person is able to demonstrate 5 years full time employment in the entertainment technology industry.

Social Security / Social Insurance Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Sex:  Male  Female  Gender Fluid/Genderqueer/Gender Variant  Non-Binary/Non-Conforming  Trans  Other

Marital Status:  Single  Married  Domestic / Common Law Partner  Divorced  Widowed

List names, relationship and ages of all dependents:

<i>Name</i>	<i>Relationship</i>	<i>Age</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Additional Information**

In order to aid the Review Committee in providing you with financial assistance, please feel free to share any additional thoughts:

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Describe the current status of health care coverage including Medicare, Medicaid, or Employment Insurance Sickness Benefit, etc.: \_\_\_\_\_

List all Union affiliations, past or present, and indicate whether currently active or inactive:

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**Employment History** *(must demonstrate a minimum of 5 years earning your living in the industry)*

Current Status:  Full Time  Free Lance  Unemployed  On Disability  Unpaid Leave  Retired

Current / Most Recent Employer: \_\_\_\_\_

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

City: \_\_\_\_\_ State/Province: \_\_\_\_\_

Zip/Postal Code: \_\_\_\_\_ Country: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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

Dates of Employment: \_\_\_\_\_

Position: \_\_\_\_\_

**If employed with the above for less than 5 years, please complete the following:**

Previous Employer: \_\_\_\_\_

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

City: \_\_\_\_\_ State/Province: \_\_\_\_\_

Zip/Postal Code: \_\_\_\_\_ Country: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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

Dates of Employment: \_\_\_\_\_

Position: \_\_\_\_\_

Previous Employer: \_\_\_\_\_

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

City: \_\_\_\_\_ State/Province: \_\_\_\_\_

Zip/Postal Code: \_\_\_\_\_ Country: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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

Dates of Employment: \_\_\_\_\_

Position: \_\_\_\_\_

*Attach additional sheets as necessary*

<b>Monthly Income (as of _____, 20____ )</b>	
Earnings	\$
Earnings of Spouse or Domestic Partner	\$
Benefits: Unemployment / Disability / Pension / Social Security	\$
Other Income ( <i>please specify</i> )	\$
<b>Total Monthly Income</b>	<b>\$</b>
<b>Monthly Expenses (as of _____, 20____ )</b>	
Rent / Mortgage	\$
Car Payment <input type="checkbox"/> Owned <input type="checkbox"/> Leased	\$
Car Insurance / Gas / Other Transportation Costs	\$
Health Insurance Premiums <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly	\$
Loan Payments	\$
Utilities - Electric / Gas / Water / Garbage	\$
Telephone / Internet / Cable	\$
Child or Spousal Support	\$
Credit Card Payments	\$
Other Expenses ( <i>please specify</i> )	\$
<b>Total Monthly Expenses</b>	<b>\$</b>

## Assistance Requested

Please indicate what type of assistance you are applying for:

- I am looking to begin ongoing counseling with a mental health care professional
- I am looking to continue my existing ongoing counseling with a mental health care professional  
Please tell us what the cost per session is and the frequency of the therapy sessions (if possible, please provide a copy of a previous bill): \_\_\_\_\_  
\_\_\_\_\_
- I am seeking to enter either an in-patient or out-patient chemical dependency recovery treatment program
- I am seeking seeking assistance with expenses incurred as a result of an inpatient emergency mental health event

If you already know the name of the mental health care provider or treatment program you wish to use, please enter their contact information below:

Provider: \_\_\_\_\_

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

City: \_\_\_\_\_ State/Province: \_\_\_\_\_

Zip/Postal Code: \_\_\_\_\_ Country: \_\_\_\_\_

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

## Required Submissions *(please submit the following with this application)*

- Proof of 5 years employment such as a print out of your annual earnings or pension provided by your employer or union
- Copy of your most recent bank statement

## Are you being assisted by other charitable organizations?

- Actors Fund - Contact: \_\_\_\_\_ Assistance provided: \_\_\_\_\_
- Actors Fund of Canada - Contact: \_\_\_\_\_ Assistance provided: \_\_\_\_\_
- Motion Picture & Television Fund - Contact: \_\_\_\_\_ Assistance provided: \_\_\_\_\_
- Will Rogers Foundation - Contact: \_\_\_\_\_ Assistance provided: \_\_\_\_\_
- Other - Please specify: \_\_\_\_\_ Assistance provided: \_\_\_\_\_

## Disclosure Regarding Financial Assistance

The undersigned Applicant understands and agrees as follows:

1. Awards of financial assistance granted by the Behind the Scenes Foundation will be dispersed on a case-by-case grant basis. Any grant of financial assistance is not an agreement by the Behind the Scenes Foundation to provide the applicant with financial assistance for any period of time or in any amount other than that specified by the Behind the Scenes Foundation in its sole and absolute discretion at the time of the grant. Grants must start to be used within three months of award, subject to extension in the sole and absolute discretion of the Behind the Scenes Foundation.
2. The amount and conditions of the grant shall be determined at the sole discretion of the Behind the Scenes Foundation's Board of Directors based, in part, upon the recommendation of a three member screening panel. The satisfaction of minimum eligibility standards does not guarantee grant approval for financial assistance. The Behind the Scenes Foundation does not discriminate based on race, religion, color, national origin, sex, sexual orientation, or political affiliation.
3. The Behind the Scenes Foundation reserves the right to condition any award or grant and at any time to modify the amount or terms of any financial assistance awarded or to terminate such financial assistance upon a change of either the grantee's or the Behind the Scenes Foundation's circumstances or the discovery of new information relevant to such financial assistance or this Application.
4. The undersigned hereby authorizes the Behind the Scenes Foundation (a) to communicate with the people and organizations listed in this Application or on supporting documentation to verify the information contained in this Application, (b) to share the Applicant's information contained in this Application with the Actors Fund, Actors Fund of Canada, Motion Picture & Television Fund, Will Rogers Motion Picture Pioneers Foundation, or any of them; and (c) to conduct a credit investigation and obtain credit reports on the Eligible Person. The undersigned hereby authorizes the people and organizations listed in this Application or on supporting documentation and credit reporting agencies to release to the Behind the Scenes Foundation, and its duly authorized representatives, any information deemed necessary by the Behind the Scenes Foundation to complete its review of this Application. Specifically, the undersigned authorizes any insurance company, organization, employer, hospital, physician or pharmacist to release any information requested by the Behind the Scenes Foundation (or its representatives) with regard to medical treatment, dates of medical service, and medical condition to the Behind the Scenes Foundation and its representatives.
5. The undersigned understands that the Behind the Scenes Foundation may request additional documentation in support of this Application as proof of need.
6. The undersigned hereby certifies that he/she has answered the foregoing questions to the best of his or her ability, and that the information provided by the undersigned is true, complete and correct. The undersigned understands that any false or misleading information will disqualify the Eligible Person from receiving any financial assistance from the Behind the Scenes Foundation. In the event a grant has been made prior to the discovery of any such false or misleading information, the Behind the Scenes Foundation reserves the right to recover from the undersigned the funds previously granted and paid.
7. Information submitted or received in connection with this Application will be disclosed to and used by the Behind the Scenes Foundation and its Board of Directors and staff in evaluating the Application, and will be held confidential unless otherwise required by law.

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Signature of Eligible Person or Applicant

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Date

**Mail to: Behind the Scenes, P.O. Box 368 Lakeville, CT 06039**

**Fax to: 646-713-2308**

**Email to: [info@behindthescenescharity.org](mailto:info@behindthescenescharity.org)**

**Please call 212-244-1421 with any questions**