PROBLEM GAMBLING | COALITION OF COLORADO

PROBLEM GAMBLING TREATMENT SCHOLARSHIP APPLICATION

This form must be filled out by the treatment provider.

Treatment Provider Information

Application Date _____ Colorado Practitioner # _____

First Name _____ Last Name _____

Verify one of the credentials listed:

- ☐ BACC
- ☐ ICGC-I
- ☐ ICGC-II

Treatment Center Name _____

Address _____ City _____ State _____ Zip _____

Phone _____ Cell _____ Email _____

Treatment Recipient Information

Initial Evaluation Date _____ First and Last Initial _____ Recipient's County & State _____

Gender:

- ☐ Female
- ☐ Male
- ☐ Other _____

Age: _____

Family Member Requesting Treatment?

- ☐ Yes
- ☐ No

Referred for Treatment by:

- ☐ PGCC
- ☐ NCPG
- ☐ Other _____

DSM Diagnosis: _____

**Client must meet the DSM-5-TR criteria for a gambling disorder to receive treatment funding. Severity levels include mild, moderate, and severe.*

PGCC Internal Use

Date Received: _____

Approved:

- ☐ Yes
- ☐ No

_____ # of sessions approved

Approved by: _____

_____ Client Code

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