



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:

Age: _____

Family Member Requesting Treatment?

- Female
 Male
 Other _____

- 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