Froedtert & Medical College of Wisconsin — Holy Family Memorial

Wellness Fund Scholarship Application

Name (please print): ______________________________ Date: ______________

Address: ______________________________ City, State, Zip: ______________________

Email: ______________________________ Date of Birth: ______________________

Phone Number: ________________________ I am a current HFM patient: ☐ Yes ☐ No

Who referred you to the Wellness Fund? ______________________________________

Who is your primary care provider? ______________________________________

Please check the program you are applying for

Check Program	Program	Time Commitment	HFM Pays	You Pay	Program Location
☐	Tobacco Independence Program	5 sessions 1:1 with a coach	$200	$25	Harbor Town Campus
☐	Wellness Center Membership	3-month commitment: Includes access to group classes, exercise equipment, pool and sauna	$113	$37	Harbor Town Campus
☐	Nutrition Coach—Online	3-month commitment: Nutrition counseling via online platform with daily nutrition emails and feedback	$170	$55	Harbor Town Campus
☐	Nutrition Coach—Full package	3-month commitment: Includes everything in the online nutrition coaching, plus 2 in-person meetings with nutritionist a month	$260	$85	Harbor Town Campus
☐	Why Weight Plus	1-year commitment: Meet regularly with a lifestyle coach and includes a fitness component for 3-months	$375	$125	Harbor Town Campus

The Wellness Fund will pay 75% of the total cost of service while the applicant pays 25%. To learn more about each program visit hfmhealth.org.

See page 2

Resources

Yes	No	
☐	☐	Employed
		Where? ____________________
		# hours/week: ____________ $/hour: ____________
☐	☐	Insurance through employer
☐	☐	Are you ready to change your lifestyle?
☐	☐	Veteran
☐	☐	Badger Care
☐	☐	Medicare
☐	☐	Medicaid

Please use the space provided below to tell us why you need financial assistance for this service:

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Please use the space provided below to tell us why you are a good candidate for the Wellness Scholarship Fund and what you will personally do to make health behavior changes if this request is approved:

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Informed Consent

The information I have provided in this application is true to the best of my knowledge and belief.

I agree to provide update information on program attendance and success to HFM and understand that failure to attend the program may result in termination of my financial assistance.

I agree to allow HFM to obtain information on my attendance and participation if approved for assistance.

______________________________ ______________

Signature Date

Mail completed form to:
Fund Development
Froedtert Holy Family Memorial Hospital
P.O. Box 1450
Manitowoc, WI 54220-1450