Wellness Fund Financial Assistance Application

The Wellness Fund is supported by generous donations to Froedtert Holy Family Memorial Fund Development Department. Its intent is to assist those, who have difficulty paying for Wellness Center programs, live a healthier life-style.

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	Wellness Fund Pays	You Pay	Program Location
☐	Parkinson's Disease Class	Six-month commitment. Classes meet weekly Parkinson's disease exercise class helps patients in all stages of the disease maintain their function and improve balance, as well as: Strengthen and stretch muscles, improve posture, increase confidence in performing daily activities, increase cardiovascular fitness and reduce stress levels.	$225	$75	Harbor Town Campus
☐	PNE (Pain Neuroscience Education) class:	Six week commitment. The PNE class helps individuals take control of their chronic pain and health and get back the life they want. The program uses a mind-body approach based on current neuroscience research and includes other strategies and exercises for treating pain.	$56.25	$18.75	Harbor Town Campus
☐	Health and Fitness Coaching	Six week commitment. Receive personalized support and coaching from a certified personal trainer, learning healthy eating habits for sustainable weight loss and optimal health.	$441	$147	Harbor Town Campus
☐	Wellness Center Membership	Six-month commitment	$238.50	$79.50	Harbor Town Campus

The Wellness Fund will pay 75% of the total cost of service while the applicant pays 25%. This fund is a jump-start to your health! After one year, the cost to you will increase in increments until you are paying the full rate for membership.

61370HF (10/23)

Applicant Information

Yes	No	
☐	☐	Employed
		Where? ______________________
☐	☐	Insurance through employer
☐	☐	Veteran
☐	☐	Badger Care
☐	☐	Medicare
☐	☐	Medicaid

Monthly Income (including all sources):

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How many persons live in you household? ______________________

Do you have insurance that would pay for any of the services provided in this application? ☐ Yes ☐ No

Tell us why you need financial assistance for this assistance and what you will personally do to make health behavior changes if this request is approved:

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Informed Consent

I certify that the above answers are and correct to the best of my knowledge.

I agree to provide updated 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

HFM STAFF: SEND COMPLETED APPLICATION TO FUND DEVELOPMENT, WESTERN AVENUE.