Holy Family Memorial

Sponsored by the Franciscan Sisters of Christian Charity

WELLNESS FUND SCHOLARSHIP APPLICATION

Name (Please print)	Today's Date	Telephone Number
Address	City/State/Zip code	
E-mail Address	DOB	I am a current patient of Holy Family Memorial ☐ Yes ☐ No
Who Referred you to the Wellness Fund?	Who is your Primary Care Provider?	

PLEASE CHECK PROGRAM YOU ARE APPLYING FOR

CHECK PROGRAM	PROGRAM	TIME COMMITMENT	HFM PAYS	YOU PAY	PROGRAM LOCATION
	1. Wellness Center Membership	Regular Use 3 Month Membership	$106	$20	HFM Wellness Center Harbor Town Campus
	2. Tobacco Independence Program	5 Sessions 1:1 with a Coach	$200	$25	Harbor Town Campus
	3a. Why Weight	1-year commitment: Meet with lifestyle coach and learn healthy lifestyles	$225	$25	HFM Wellness Center Harbor Town Campus
	3b. Why Weight Plus	1-year commitment: Meet with lifestyle coach and includes a fitness component	$325	$30	
	4. Nutrition Counseling Wellness Center Member	1:1 Sessions with a nutrition coach over a 3-month period – Full Package	$295	$25	HFM Wellness Center Harbor Town Campus
	Nutrition Counseling Non-Wellness Center Member		$325	$30	
	5. Total Control® Program	Three 1:1 sessions with a Total Control ® Trainer for 1 hour each working on pelvic pyramid exercises	$130	$20	HFM Wellness Center Harbor Town Campus

(More info on Back)

RESOURCES

Yes	No		Yes	No	
_____	_____	Employed	_____	_____	Veteran
______________		Where?	_____	_____	Badger Care
______________		# hours/week, $/hour	_____	_____	Medicare
_____	_____	Insurance through employer	_____	_____	Medicaid
_____	_____	Are you ready to change your lifestyle?			

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

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:

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 ____________________

HFM Staff: SEND COMPLETED APPLICATION TO FUND DEVELOPMENT, WESTERN AVENUE, ATTENTION: MONICA NICHTER