Holy Family Memorial

*in affiliation with*

Froedtert & Medical College of Wisconsin

# 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:

_____

_____

_____

_____

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: PATTI GLASER**