## Applicant Acknowledgement

**Mission:** The Hope of Shades Foundation's mission is to raise money to be used for the education and treatment of eating disorders.

**Purpose:** The purpose of The Hope of Shades Foundation is to help support treatment for individuals willingly seeking attention for eating disorders. The Hope of Shades Foundation will sponsor 80% of their treatment costs. If client forgoes treatment early, The Hope of Shades Foundation is not responsible to cover the remaining treatment costs and applicant is held liable.

**Consideration:** In order to be considered for scholarship, the application must be completed in its entirety and be completed to the best of the applicant's knowledge. The applicant must be forthcoming with information and provide additional information or clarity as needed. Scholarships will be considered on an individual basis and reviewed by the application review committee on a first submitted, first reviewed basis.

**Confidentiality**: Information completed on this application will be used exclusively for the purpose of determining financial contribution from the Hope of Shades Foundation. This information will not be used, provided, or discussed with any other individuals besides the applicant and the Application committee.

**Approval Statement**: If approved, a statement will be provided to the approved treatment facility with only the applicants Name, Contact Information, Approval Amount, length of time approved. No medical or social history will be distributed to the treatment facility. However, the treatment facility may be contacted to discuss amenities for the applicant to ensure there are the following: 1. The treatment facility specializes in the applicants main disorder, 2. The treatment facility has room, 3. The treatment facility rates would be covered by the scholarship. _____ Initials

**Liability:** Neither The Hope of Shades Foundation, its Board of Directors, affiliates, or volunteers are responsible for physical injury, property damage, emotional distress, treatment decisions, treatment plans, medical direction or prescriptions. Those decisions are exclusively between the applicant and the treatment facility. _____ Initials

**Monetary Decisions:** Scholarship decisions will be decided based upon available funds, cost of treatment, after care availability, financial need, willingness, family participation and need for treatment. _____Initials

**Reapplication:** If you are not awarded a scholarship, you may not reapply unless given specific permission from a Board member or a committee. _____ Initials

I agree and understand the above statements and will complete the Scholarship Application to the best of my knowledge.

Applicant Full Name_____ Date _____

Applicant Signature_____

## Applicant Financial Responsibility Agreement

**Financial Statement:**

The Hope of Shades Foundation , Its Board Members, Affiliates and Volunteers are not responsible for any funds not covered by the scholarship approved.

All incurred expenses over and above the approved dollar amount from the foundation are the responsibility of the applicant. Any financial arrangements including collection of payments are between the applicant and the treatment facility. This includes incidental fees including travel, prescriptions, personal items, stamps, paper, books, materials, outings, and any other fees incurred with the treatment facility.

If the applicant leaves before the funds are earned or distributed, the applicant is responsible for paying all fees to the treatment facility that he/she has incurred.

Any awarded scholarship will be paid directly to the treatment facility upon verification of admission and invoicing from the treatment facility. All funds will be applied directly to the applicants account at the facility; no funds will be distributed to the applicant.

Applicant Full Name_____Date _____

Applicant Signature_____

## Confidentiality Agreement

**Confidentiality Statement:**

I agree that the receipt of this scholarship is strictly confidential and any conversation around finances, available funds, balances on accounts will be discussed solely with the Executive director or Financial Director of the treatment facility.

Any conversation before, during or after treatment with other clients, treatment facility personnel, or anyone else would be a breach of this confidentiality agreement and the funds distributed may be subject to revocation (removal) and forfeiture.

Applicant Full Name_____Date _____

Applicant Signature_____

## Willingness and Family Participation Statement

**Willingness**: I agree that I am applying for treatment under my own free will and will be available and willing to attend treatment and stay the recommended time frame until the scholarship is exhausted or until facility staff recommends otherwise. ____ Initials

I agree to follow the recommendations of the staff at the treatment facility for treatment plan while I am in the treatment facilities care including but not limited to attending 12 step recovery meetings, therapy appointments, reading, and writing assignments, and group meetings.

I agree that I will participate in treatment activities to the best of my ability and will be open and willing to following directions.

**Family Participation:** I agree that if asked, I am willing to take steps to invite family members to family week to further my recovery if it is recommended by the staff during treatment. _____ Initials

**Childcare:** If applicable, I acknowledge that if I am selected for scholarship, I have a place for my child or a child to stay that is safe. _____Initials

Applicant Full Name_____Date _____

Applicant Signature_____

## Application for Financial Assistance- Section 1

The Hope of Shades Foundation provides scholarships and grants to assist those seeking treatment for eating disorders. Our ability to provide assistance depends on the determination of need and ability to pay. All information obtained through the application process is confidential and will not be shared with any third party. The Hope of Shades Foundation prohibits discrimination against and harassment of any employee or any applicant because of race, color, national or ethnic origin, age, religion, disability, sex, sexual orientation, gender identity and expression, veteran status (special disabled veterans, disabled veterans and Vietnam-era veterans), or any other characteristic protected under applicable federal or state law. All members who are responsible for the development and implementation of The Hope of Shades programs or activities are charged to support this effort and to respond promptly and appropriately to any concerns that are brought to their attention. The Hope of Shades Foundation is not liable for any injuries or deaths sustained while participating in the treatment programs.

**Personal Identification Information:**

| | | | | |
|---|---|---|---|---|
| **Full Name:** | | | | |
| **Address, City, State, Zip** | | | | |
| **Date of Birth** | | **Social Security #** | | |
| **Home Phone** | | **Cell phone** | | |
| **Work Phone** | | **Email Address** | | |
| **Marital Status** | ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Other _____ | | | |
| **Citizenship** | **Are you a U.S. Citizen?** | | | |
| **Height** | | **Weight** | | |

Currently Seeking treatment for (check which box applies):

- ☐ Compulsive overeating
- ☐ Anorexia
- ☐ Bulimia
- ☐ Binge/Purge

Other:

Please rate from 1 to 10 (with 10 being the greatest) the severity of this addiction:

Please rate from 1 to 10 (with 10 being the greatest) the urgency to seek treatment:

**Please answer to best of your knowledge the following questions:**

| |
|---|
| **Have you been convicted of a felony? If yes, please elaborate:** |
| **Do you have any outstanding warrants or a pending lawsuit?** If yes, please elaborate**:** |
| **Have you been mandated to attend treatment by a judicial system? If yes, please elaborate:** |
| **What is the estimated dollar amount needed?** |
| **Have you received funds from The Hope of Shades Foundation in the past?** |
| **Where would you like to receive treatment?** |
| **Are you an employee or a family member of an employee of a treatment facility in the US?** |
| **Are you currently employed? Would obtaining time off from your employer be an issue?** |
| **Number of family members in household:** |
| **Do you have dependents? If you were to attend treatment, would you be able to arrange care for dependents?** |

| |
|---|
| **Have you been treated for addiction before? If so, where and how long ago? Are you in relapse currently? Longest period of abstinence?** |
| **Do you have a family history of addiction or substance abuse?** |
| **Have any immediate family members received funds from The Hope of Shades Foundation?** |
| **Are you an officer for any foundation currently? If so, which one?** |
| **Do you see a therapist on a regular basis? If so, how often?** |
| **Do you have face to face 12 step meetings in your area you attend?** |
| **Do you attend phone or online 12 step meetings?** |
| **What makes you feel like this is right for you?** |
| **How will treatment help you?** |
| **Why are you seeking treatment now?** |
| **Would you be willing to provide detailed financial information?** |
| **Will you be willing to submit to a background check?** |
| **Are you open to a personal interview?** |
| **Have you exhausted all possible resources?** |

**Please provide a brief essay (500 words or less), on who you are, how disordered eating has impacted your life, and why you are seeking treatment:**

**Upon leaving treatment, I agree to follow the treatment plan as outlined from the treatment facility and any additional programs set forth for my recovery.**

_____ _____ _____

**Signature of Applicant:** **Printed Name:** **Date:**

## Application for Financial Assistance- Section 2

The Hope of Shades Foundation provides scholarships and grants to assist those seeking treatment for eating disorders. Our ability to provide assistance depends on the determination of need and ability to pay. All information obtained through the application process is confidential and will not be shared with any third party. The Hope of Shades Foundation prohibits discrimination against and harassment of any employee or any applicant because of race, color, national or ethnic origin, age, religion, disability, sex, sexual orientation, gender identity and expression, veteran status (special disabled veterans, disabled veterans and Vietnam-era veterans), or any other characteristic protected under applicable federal or state law. All members who are responsible for the development and implementation of The Hope of Shades programs or activities are charged to support this effort and to respond promptly and appropriately to any concerns that are brought to their attention. The Hope of Shades Foundation is not liable for any injuries or deaths sustained while participating in the treatment programs.

| **Personal Information** | | | | |
|---|---|---|---|---|
| Name | | | | |
| Address | | | | |
| City State Zip | | | | |
| Date of Birth | | Social Security # | | |
| Residence | Rent/Own? | How Long? | Monthly Pmt | Current? Yes/No |
| Home phone | | | | |
| Cell Phone | | | | |
| Work Phone | | | | |
| Emergency Contact | Name: Relationship:<br>Phone: | | | |

**Employment**

| | |
|---|---|
| Employer | |
| Address | |
| City State Zip | |
| | How Long Income / Month $ |

**Insurance Information**

| | |
|---|---|
| Insurance | Relationship to insured: |
| Group/ID | |
| Address | |
| Contact | |
| | |

| Family Data | |
|---|---|
| Family Data | Married: ☐ Divorced: ☐ Separated: ☐ Widowed: ☐ |
| Spouse Name | |
| Employer | Title: |
| Contact | Cell: Work: |
| Dependents | # of Children: Other Dependents: |
| | |
| Monthly Income | Self: $ Spouse: $ Other: $<br><br>Do you qualify for public assistance? Program? |
| Extraordinary Family Expenses | (Items other than expected monthly costs ) |

| | |
|---|---|
| Assets | |
| Real Property | Address: |
| | Payment: $ Mortgage Balance: $ |
| Bank Balances | Checking: $ Savings: $ IRA: $<br>Stocks: $ Investments: $ |
| Any other assets | |
| | |
| Expenses Liabilities | Car(s) Make, Model, Year:<br>Payment(s) $ Balance: $ |
| Insurance | Health: $ Auto: $ Life: $ Other: $ |
| Utilities | Electric/Gas: $ Water: $ Other: $<br>Cable: $ |
| Child Care | Daycare: $ Additional Care: $ |
| Credit Card Debts | Card(s): Balance: $ Monthly Pmt: $<br>Balance: $ Monthly Pmt: $<br>Balance: $ Monthly Pmt: $<br>Balance: $ Monthly Pmt: $ |
| Misc Loans | |
| Other | |
| | |

**Upon leaving treatment, I agree to follow the treatment plan as outlined from the treatment facility and any additional programs set forth for my recovery.**

_____ _____ _____

**Signature of Applicant:** **Printed Name:** **Date:**