

Gail R. Schoenbach F.R.E.E.D. Foundation Scholarship Request Form

Please fill out completely. Incomplete applications will not be processed.

SECTION I: General Information

Name of Applicant: _____

Address: _____

Home Telephone: _____ Cellular: _____

Work Telephone: _____ Email: _____

Age: _____ Marital Status: _____

With whom do you reside? (List relationship to each person, age and occupation)

Please describe employment status (include occupation, # of hours/week worked, salary, length of employment and work history. If you are a student, please state name and location of school, what grade/year you are in, and your current status, i.e. f/t, p/t, on medical leave, etc.):

Name of Health Insurance:

Do you have mental health benefits? (*Yes / No*) (circle one); If yes, what does your insurance cover?

SECTION II: Symptoms and Treatment History

Height: _____ Current Weight: _____ Age when Eating Disorder first developed:

Do you:

____ *Restrict*

____ *Binge*

____ *Purge*

____ *Use Laxatives*

____ *Use Diet Pills/Diuretics*

____ *Over exercise*

Do you experience/Have you experienced:

____ *self injury*

____ *anxiety*

____ *depression*

____ *trauma history*

Current Medications (include who prescribed and what it was prescribed for):

In your own words, please describe your eating disorder:

Please describe your current physical health (include any health issues, even if not related to the ED):

Have you ever been hospitalized (ER visits, hospitalizations in a medical setting related to the ED, inpatient or residential treatment, or any other psychiatric hospitalization)? If yes, please list where and for how long:

Please describe previous outpatient treatment efforts (including day treatment, intensive outpatient, individual therapy, nutrition, groups, etc):

Information about your Treatment Team:

(If you do not see the following treatment providers, please state why not. If you have seen them in the past, but not currently, please state when, for how long and list their contact information.)

Name and phone number of **individual therapist**:

How often do you see this person, and for how long have you worked with him/her?

Name and phone number of **nutritionist**:

How often do you see this person, and for how long have you worked with him/her?

Name and phone number of **physician/primary care doctor**:

How often do you see this person, and for how long have you worked with him/her?

Name and phone number of **psychiatrist**:

How often do you see this person, and for how long have you worked with him/her?

Please list anyone else on your treatment team not listed above:

SECTION IV: Consent to contact treatment providers

This **MUST** be filled out and signed in order to process request. When signed by you, F.R.E.E.D. may contact any and all of the treatment providers and facilities listed in your application above, and you authorize said treatment providers to disclose treatment/health information to F.R.E.E.D.

I _____, authorize the Gail R. Schoenbach F.R.E.E.D. Foundation, to contact my providers and for them to release information pertinent to my treatment

I am requesting this information be released at the request of the individual.

This authorization shall remain in effect until one year from date below.

I am aware that I have the right to revoke this authorization, in writing, at any time by sending such written notification to The F.R.E.E.D. Foundation.

Signature of Applicant

Date

*Thank you for completing the F.R.E.E.D. Scholarship request form. Please mail or fax **COMPLETED** application to the address below.*

F.R.E.E.D. FOUNDATION * 18 CHESTNUT HILL * WARREN, NJ 07059 * 908-756-9260 * 908-334-2978 * FAX 908-756-9261