Non-Profit 301(c)(3) tax ID # 26-3244522

Rebecca's Eating Disorder Foundation Partial Scholarship Application Packet

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Mission Statement

Rebecca's Eating Disorder Foundation is to provide financial assistance for inpatient treatment costs to all qualified individuals through a well-administered scholarship fund program.

Vision Statement

Rebecca's Eating Disorder Foundation is to see individuals who are struggling with eating disorders successfully treated regardless of their ability to pay.

Values Statement

We are an organization that facilitates *Respect*.

We believe in the value, worth, and dignity of all people. Rebecca's Eating Disorder Foundation espouses respect of one's self and adhering to these concepts intra-personally. We respect the diversity of races and cultures, belief systems and practices, and the different religious faiths of the people and communities we serve. We accept others as fellow human beings, affirm the rights of others, foster a safe environment, and maintain integrity during our interaction with others.

We are an organization that facilitates *Collaboration*.

We cooperate with other service providers and other systems that also give support and care to the clients and communities we serve. Through collaboration we foster the trust that is essential to building relationships. We endeavor to model leadership, competency while we build strong working relationships and connections with other providers, and organizations to best serve our clients and communities.

We are an organization that demonstrates *Compassion*.

We believe in a model of full recovery in which we all participate. In responding to an ill person we find an opportunity for caring, connection, and compassion present in relationships. We feel this extends not only to those seeking help, but also to friends, families, and caregivers. We seek to empower, and are committed to showing empathy and help and hope for all people.

Instructions for Completion of Scholarship Request Form

1. It is preferred that the applicant complete the information packet, however, if the applicant is unable, unwilling, or mentally incompetent to complete packet, then the applicant's parents, caregivers, other family members, or practitioner may complete or aid in completion of packet. The applicant and guardian (if appropriate) must sign the consent form and waivers, however, in order to be considered for the scholarship. Rebecca's Eating Disorder Foundation™ requires original signatures; therefore, the original Scholarship Request Form and Release of Information forms must be mailed in with original signatures. However, in order to expedite the process, applicants may also fax or email their information to expedite the selection process. Therefore, applicants need to fax or email packets AND mail in original forms to Rebecca's Eating Disorder Foundation™.
2. The questionnaire packet is in expandable PDF form. Therefore, each item within the questionnaire is an expandable area, so that you may type directly into the application.
3. Certain sections of the application form need to be completed by the appropriate members of the health care team. It is preferred that the practitioner send via the best method in which they desire to be contacted. All practitioners must be able to be contacted, and specify how they would like to be contacted in a confidential manner. To ensure confidentiality, consent forms must be signed for each practitioner. The following delivery method is acceptable:
    - Email (please send directly from practitioner's email address; electronic signatures are acceptable)

S c h o l a r s h i p R e q u e s t F o r m

All application sections should be typed directly into this form. Any text box can be made larger to accommodate your answers, but please limit your responses to a maximum of one page per question. When complete, please print the form, sign where indicated and submit it directly to:

Rebecca's Eating Disorder Foundation – Request Form
13700 Alton Parkway, Suite 154-180
Irvine CA 92618
EMAIL: application@RebeccasFoundation.org

Section I: General Information

Date Submitted	

1. **Applicant Information**

Name (First, Middle Initial, Last)	
Date of Birth and Age	
Address	
City, State and Zip Code	
Home Telephone	
Cell Number **Work Number**	
Marital Status	
Email	

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

Name	Relationship to me	Age	Occupation/Grade in School

3. Please describe your employment. (Include your occupation, the number of hours per week you work, your salary, and how long you have worked there.) **Students please note the name of your school (if you are home-schooled), what your grade is, and whether you are enrolled full time, part time or are on any type of leave of absence.**

Section II: Symptoms

4. In your own words, describe how you have been impacted by your eating habits/disorder. Include the length of time you feel you have had difficulty with eating and if you are trying to change how you use food in your life. Please include thinking patterns, behavior patterns, and emotional difficulties that you have encountered as a result of your eating. Please also include any "purging" behaviors in these responses, including over-exercising, use of diet pills/laxatives, and restrictive eating habits.

5. How has your eating disorder impacted the important relationships in your life?

6. Please describe your current physical health and how you believe your eating habits/disorder has affected it.

7. Mark with an X any of the behaviors listed below that you have engaged in or experience. (Mark all that apply)

	Restricting		Over Exercising
	Bingeing		Using Laxatives
	Purging		Using Diet Pills/Diuretics
	Anxiety		Trauma
	Depression		Desire to Cause Self-Injury
	Dissociation (feeling separate from body)		Other (describe):

8. What is your primary goal while participating in treatment?

9. How would you define long-term success regarding treatment? In other words, what is your hope for desired change while participating in this treatment facility?

Section III: Treatment History & Recommendations

10. Have you ever been hospitalized? If yes, please list the name of the hospital, the dates you were treated there, and what resulted from this treatment. (This includes any ER visits, hospitalizations relating specifically to eating disorder, inpatient residential treatment or any other psychiatric hospitalizations.)

11. List any medications you are taking or have been prescribed:
(Please include the doctor that prescribed it and what it was prescribed to treat.)

12. Treatment Team Information: Please include who you see, what their role is in your treatment, whether you see them currently and, if not, clearly state why you are no longer seeing them. Also note how long you were seen by each practitioner.

A. Name and contact information of your *primary therapist*:

How often do you go to therapy with this therapist? How long have you been seeing this person? How has therapy been helpful? What have you learned thus far?

B. Name and contact information of your *nutritionist/dietitian*:

How often do you meet with your nutritionist? How long have you been seeing this person? How has this process been helpful? What have you learned thus far?

C. Name and contact information of your primary care physician:

How often do you see this doctor? How long have you been seeing this person?

D. Name and contact information of your *psychiatrist*:

How often do you see this doctor? How long have you been seeing this person? What medications have they prescribed, and are you taking them as prescribed?

E. Please note anyone else you have seen as a part of your treatment team that is not listed above.

13. Please attach letters of recommendation from your supports and treatment team.

a. Parents/Spouse/Friend – please include your experience of your child's/spouse's/friend's eating disorder and note your perception of his/her difficulty with recovery

b. Primary Therapist – please include a general summary of treatment goals, progress, and issues that need to be followed up on while inpatient

c. Nutritionist – please include height, significant weight changes across treatment, any dietary concerns/difficulties and current meal plan

d. Primary Care Physician – please also include recent lab work

e. Psychiatrist – please include current medication regime and success thus far in treatment

Section IV: How You Would Like Rebecca's Eating Disorder Foundation™ to Help

14. Have you contacted an inpatient, PPH, IOP or outpatient ED treatment facility? (If so, please provide the name and address of the facility, as well as the anticipated cost and length of treatment.)

15. What is the anticipated duration and total cost of the treatment you are seeking?

(Your therapist or doctor may be helpful in determining this)

16. What is the name and phone number of your health insurance company and what is your policy number? What is the Social Security Number of the policy holder?

17. Do you have mental health benefits? If yes, please note what kinds of mental health care your insurance covers.

18. Please list the amount you are able to contribute toward the cost of your treatment (this includes patient, family, or other personal contributors, and this money will be contributed directly to the hospital or facility)**:**

19. List any other funds you have to use for your treatment (i.e. insurance, personal funds)

20. What approximate amount are you seeking for Rebecca's Eating Disorder Foundation™ to provide to the treatment center?

_____ _____

Signature of applicant **Date**

Incomplete or incorrect information may cause a delay in the processing of your request.

Checklist for completed Rebecca's Eating Disorder Foundation™ Request Form

- ☐ Application completed
- ☐ Letters of recommendation/referral from:
  - ☐ Primary therapist
  - ☐ Primary Care Physician
  - ☐ Psychiatrist
  - ☐ Nutritionist/Dietitian
  - ☐ Parent/spouse/friend
  - ☐ Treatment Center
- ☐ Current lab work (within 1 month of Request form Submission)
- ☐ Completed release of information for each designated party
- ☐ Essay
- ☐ Fax or email application
- ☐ Mail or bring hard copy of the application to Rebecca's Eating Disorder Foundation

Rebecca's Eating Disorder Foundation™
13700 Alton Parkway, Suite 154-180
Irvine CA 92618

Consent and Authorization to Release Information

I authorize Rebecca's Eating Disorder Foundation™ to release to and receive from:

Name: _____

Address: _____

_____

Phone/Fax: _____

The following information:

- ☐ Initial Assessment information
- ☐ Follow-up Assessment information
- ☐ Therapy progress information
- ☐ Phone consultation and/or written information for continuation of care

Dates of treatment to release: _____

Contained in the record of/concerning:

Patient: _____

Address: _____

_____

Date of birth: _____ SS# _____

I understand that I may revoke this consent to release information in writing at any time, except to the extent that action has already been taken in reliance thereon. In any event, upon fulfillment of the above-stated purpose, this consent will automatically expire one year from the date signed.

Patient Signature: _____ Date:_____

What to Expect Upon Completion of Scholarship Application

REBECCA'S EATING DISORDER FOUNDATION™
Process for Reviewing Applications

1. Once you have completed and turned in your application to the REBECCA'S EATING DISORDER FOUNDATION™, your application will be reviewed by the Clinical Advisory Board, which is a group of 3-5 eating disorders specialists, doctor, and/or Registered Dietitian.
2. The Clinical Advisory Board will review all applications and will make suggestions for acceptance into the REBECCA'S EATING DISORDER FOUNDATION™ program. Recommendations will be based on ranking the following criteria on a likert scale (determining severity on value from 1-5, 5 being the worst case):
    a. Urgency of need (based on APA criteria)
    b. Ratio of income to expenses
    c. Insurance provisions
    d. Willingness of family to be involved
    e. Willingness of patient to involve family
3. Once recommendations have been made to the Board of Directors, the Board will decide how much funding will be allocated to the scholarship recipients. Scholarship amounts will be based on available funds and potential cost of treatment.

Notification of Award

1. Each recipient will be notified via phone call and/or letter as soon as the decision has been made for award, with the amount of said award indicated.
2. An award letter will be mailed to the recipient and a copy will be faxed or mailed to the treating facility.

Completion of Waivers

1. Recipients must sign and complete waivers of treatment (see page xx) in order to participate in the REBECCA'S EATING DISORDER FOUNDATION™ process.
2. The waivers include the following:
    a. RELEASE, WAIVER OF LIABILITY, ASSUMPTION OF RISK, AND HOLD HARMLESS AGREEMENT (see Addendum A)
    b. SCHOLARSHIP RECIPIENT'S CONTACT INFORMATION and AGREEMENT TO TERMS AND CONDITIONS (see Addendum B)

Completion of Questionnaires

1. Each recipient agrees to complete a series of questionnaires once they have been accepted as a REBECCA'S EATING DISORDER FOUNDATION™ recipient. These questionnaire results will be administered to the treating facility to aid in your treatment.

2. Each recipient agrees to complete said questionnaires at the following intervals, post-discharge from their treating facility:
    a. Upon discharge
    b. 6-months
    c. 1 year
    d. 2 years

Progress Forms

1. During the course of treatment, each hospital has agreed to complete weekly progress reports to inform the REBECCA'S EATING DISORDER FOUNDATION™ board of the individual's treatment progress, as well as the estimated need for continued treatment length and potential cost of continued treatment. This is to inform the Board of Directors and the Clinical Advisory Board of your ongoing treatment needs. Financial consideration of meeting these ongoing needs will be subject to Board and/or Clinical Advisory Board approval.
2. See Addendum A for a copy of the Weekly Progress Forms

Completion of Treatment & Post-Treatment Follow-Up

1. Once treatment is complete, recipients are requested to complete the aforementioned questionnaires for follow-up and research purposes.
2. Recipients are also requested to write a summary of their experience with the REBECCA'S EATING DISORDER FOUNDATION™ process and whether they felt that their treatment was "successful". This will aid the REBECCA'S EATING DISORDER FOUNDATION™ process and future potential recipients.

13700 Alton Parkway, Suite 154-180
Irvine CA 92618
Addendum A

Weekly Progress Form **Date: _____**

Client :_____ DOB:_____ Height _____

Diagnoses:_____ Current Weight:_____

Goals or Progress made towards Goals:

1. _____
2. _____
3. _____
4. _____
5. _____

Impediments in reaching goals (e.g., client refusal to engage in treatment, parental resistance, etc):

1. _____
2. _____
3. _____
4. _____
5. _____

Anticipated length of stay/discharge date from current level: _____

_____

Further clinical needs for successful treatment:_____

_____

Prognosis: Poor Fair Good Excellent

_____ _____

Clinician Date

Rebecca's Eating Disorder Foundation™
13700 Alton Parkway, Suite 154-180
Irvine CA 92618
Addendum B

RELEASE, WAIVER OF LIABILITY, ASSUMPTION OF RISK, AND HOLD HARMLESS AGREEMENT

To be signed by person for whom Rebecca's Eating Disorder Foundation™ provides a scholarship. This is an important legal document. Read it carefully before signing.

BY COMPLETING THIS FORM YOU ARE PROVIDING US YOUR CONSENT TO COLLECT, STORE AND USE THIS FORM, WHICH CONTAINS CERTAIN PERSONAL INFORMATION ABOUT YOU OR YOUR CHILD.

I ,_____ [*insert name of person for whom the scholarship is being provided],* am accepting the scholarship which was granted by Rebecca's Eating Disorder Foundation™, as financial assistance for inpatient treatment costs for my eating disorder treatment at _____ _____ [*insert name of facility at which treatment will be provided*].

By accepting the Scholarship, I agree that the determination by Rebecca's Eating Disorder Foundation™, as to any interpretation of any aspect of the Scholarship or Scholarship Program, or whether a recipient of the Scholarship has complied with any provision of the Scholarship or Scholarship Program, shall be final and binding.

RELEASE AND HOLD HARMLESS:

IN FURTHER CONSIDERATION OF MY RECEIPT OF THE REBECCA'S FOUNDATION™ SHOLARSHIP FOR MY TREATMENT FOR MY EATING DISORDER, I AGREE TO RELEASE AND HOLD HARMLESS REBECCA'S EATING DISORDER FOUNDATION™ AND ITS DIRECTORS, OFFICERS, AGENTS, VOLUNTEERS, AND FROM AND AGAINST ALL TAXES OR OTHER AMOUNTS DUE TO GOVERNMENTAL BODIES BY ME AS WELL AS ALL CLAIMS, EXPENSES, LOSSES OR DAMAGES TO PROPERTY OR PERSON OF ANY KIND, CAUSED IN WHOLE OR IN PART, DIRECTLY OR INDIRECTLY, BY THE ACCEPTANCE, POSSESSION, OR USE OF THE SCHOLARSHIP. THIS RELEASE EXTENDS TO CLAIMS FOR THE NEGLIGENCE OF REBECCA'S FOUNDATION™.

INDEMNIFICATION:

IN FURTHER CONSIDERATION OF MY USAGE OF THE SCHOLARSHIP, I AGREE AND PROMISE TO INDEMNIFY AND DEFEND REBECCA'S FOUNDATION™ AGAINST ANY AND ALL CLAIMS, LIABILITIES, LOSSES, DAMAGES OR EXPENSES OF ANY KIND INCLUDING, BUT NOT LIMITED TO, (i) CLAIMS FOR THE NEGLIGENCE, FAULT OR OTHER TORT OF REBECCA'S FOUNDATION™; (ii) PAYMENT OF ANY MEDICAL LIENS OR ANY OTHER TYPE OF LIEN; AND (iii) PAYMENT OF REASONABLE ATTORNEYS' FEES ARISING FROM OR IN ANY WAY CONNECTED WITH ANY INJURIES, DAMAGES OR LOSSES SUSTAINED FROM THE USE OF THE SCHOLARSHIP, PROVIDED THAT THIS INDEMNIFICATION SHALL NOT EXTEND TO CLAIMS FOR REBECCA'S FOUNDATION™ INTENTIONAL OR RECKLESS MISCONDUCT OR GROSS NEGLIGENCE.

AGE:

I hereby represent and warrant to Rebecca's Eating Disorder Foundation™ that I am not a minor and that I have completely read and understand the terms and conditions of this Release and voluntarily agree to be bound by this Release.

If I am a minor I understand that the signature of my parent/legal guardian is required and will operate as acceptance of the terms of this Release on my behalf and their express indemnification of Rebecca's Eating Disorder Foundation™, as stated herein.

REPRESENTATIONS AND WARRANTIES:

If I am a minor, by signing below my parent or legal guardian represents and warrants that he or she is my parent or legal guardian.

GOVERNING LAW:

I agree that this document will be governed by and interpreted under the laws of the State of California, USA, without regard to principles of conflicts of law. I agree that any legal action brought by me or Rebecca's Eating Disorder Foundation™ with regard to or arising out of any matters set forth in this document shall be brought only in an appropriate state or federal court in California. I consent to the jurisdiction and venue of such courts for these purposes.

SEVERABILITY:

I agree that if a court determines that any provision of this Release is invalid or unenforceable, then that provision shall be modified or severed to the maximum extent permitted by law. However, any and all other provisions shall remain valid and be given full force and effect in a valid and enforceable manner to accomplish the purpose of this Release, which is that it shall be an enforceable release of liability and indemnification of Rebecca's Eating Disorder Foundation™.

ACKNOWLEDGEMENT:

I have completely read and understand the terms and conditions of this Release and voluntarily agree to be bound by this Release. I have represented to Rebecca's Eating Disorder Foundation™ that I am either not a minor and have signed this Release or that I am a minor and have signed this Release and my parent/legal guardian has also signed this Release.

RELEASOR

_____ _____

Signature of Releasor Date

Releasor's Social Security Number: _____

Releasor's Name: _____

Releasor's Address: _____

Releasor's City, State, Zip Code: _____

Releasor's Telephone: _____ Cell _____

Signature: _____ Date: _____

Rebecca's Eating Disorder Foundation™
13700 Alton Parkway, Suite 154-180
Irvine CA 92618

Addendum C

SCHOLARSHIP RECIPIENT'S CONTACT INFORMATION and AGREEMENT TO TERMS AND CONDITIONS

To be completed by RECIPIENT of Rebecca's Eating Disorder Foundation™ Scholarship. This is an* important legal document. *Read* carefully before *signing.

BY COMPLETING THIS FORM YOU ARE PROVIDING US YOUR CONSENT TO COLLECT, STORE AND USE THIS FORM, WHICH CONTAINS CERTAIN PERSONAL INFORMATION ABOUT YOU OR YOUR CHILD.

THIS FORM IS TO BE COMPLETED BY THE RECIPIENT OF A REBECCA'S FOUNDATION™ SCHOLARSHIP AS PROMPTLY AS POSSIBLE AND RETURNED TO REBECCA'S EATING DISORDER FOUNDATION™ AS INDICATED BELOW.

1. My name is:_____
2. My date of birth is: _____
3. My address is: _____

   _____

   _____
4. My Phone Number is: _____ Cell: _____
5. My Email Address is: _____
6. My Social Security Number is: _____

By accepting the scholarship funds, and signing below, I hereby agree (and, if I am under the age of legal majority, my parent or legal guardian agrees on my behalf):

a. To be bound by the terms and conditions of the Rebecca's Eating Disorder Foundation™ Scholarship Program as in effect from time to time and that Manna Scholarship Fund, Inc., in its sole discretion may determine whether or not I have qualified and continue to qualify for the scholarship.

b. To allow Rebecca's Eating Disorder Foundation™ or its authorized representative to

collect, store and use personal information concerning me in connection with the scholarship described above and to share such personal information with third parties who may help Rebecca's Eating Disorder Foundation™ administer the scholarship described above.

c. To complete such other documents that Rebecca's Eating Disorder Foundation™ shall reasonably require from time to time to administer the award.

d. That this document will be governed by and interpreted under the laws of the State of California, USA, without regard to principles of conflicts of law. I agree that any legal action brought by me or Rebecca's Eating Disorder Foundation™ with regard to or arising out of any matters set forth in this document shall be brought only in an appropriate state or federal court in California. I consent to the jurisdiction and venue of such courts for these purposes.

e. That the determination by Rebecca's Eating Disorder Foundation™ as to any interpretation of any aspect of the Scholarship, or whether a recipient of the Scholarship has complied with any provision of the Scholarship, shall be final and binding.

SIGNATURES

I have completely read and understand this form and Agreement. I have represented to Rebecca's Eating Disorder Foundation™ that I am either not a minor and have signed this form and Agreement, or that I am a minor and have signed this form and my parent/legal guardian has also signed this form and Agreement.

SIGNATURE OF RECIPIENT OF SCHOLARSHIP

_____

Signature of Recipient Date

SIGNATURE OF PARENT OR LEGAL GUARDIAN ***(Parent/Guardian signature required below if Transferee is under 18 or is considered a minor in her or his location of residence).***

_____

Signature of Recipient Date

Please return this form to Rebecca's Eating Disorder Foundation™

13700 Alton Parkway, Suite 154-180

Irvine CA 92618

OR application@RebeccasFoundation.org