WATERSTONE
Foundation for Eating Disorders

# Financial Aid Program
# Clinical Application

Last revised January 10, 2020

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## Mission Statement

WaterStone Foundation provides access to need-based financial assistance to individuals with an eating disorder diagnosis who are seeking treatment.

## Financial Award Criteria

- Individual must have an eating disorder diagnosis or is being evaluated/assessed for an eating disorder by a licensed health or mental health professional. DSM5 diagnoses include: Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder, Other Specific Feeding or Eating Disorder.
- The financial award is intended to assist in the cost of the treatment program which the individual wishes to enter; therefore, monies will be paid directly to the treatment provider.
- The treatment provider must be adherent to current best practices for eating disorders as defined by the American Psychiatric Association, the Academy of Eating Disorders, and regulatory bodies of the respective multidisciplinary professional team members.
- Financial awards are not intended to cover payments for past treatment.
- WaterStone has established partnerships with four clinics (contact information listed on website) who have agreed to follow our program process and discount their standard rates by 25%. If you would like us to consider a different provider, this request will be considered but the process of onboarding a new provider may be lengthy and postpone your treatment.

Special thank you to Moonshadow's Spirit Foundation for permitting WaterStone Foundation to modify and use their application materials.

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# Instructions for Completion of Financial Award Application Form

1 . It is preferred that the applicant complete the information packet. If the applicant is under 18, a parent or guardian may aid in completion of the packet. The applicant and guardian (if applicable) must sign the application form. WaterStone Foundation requires original signatures. Therefore, a hardcopy of the Financial Award Application Form and Release of Information forms must be sent via mail or courier with original signatures.

2. In order to best protect your confidentiality, please print a hard copy, complete by hand, and email or mail/courier your completed application.

3. As part of the application process we will required documentation of your treatment history as well as an in-take assessment from a participating treatment provider. To ensure confidentiality, you will need to sign a release of information for each of your treatment teams or providers.

If there are questions regarding any of the items to be completed, please contact WaterStone Foundation at financialaid@waterstonefoundation.ca.

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# Process for Reviewing Applications

1. Once you have completed and submitted your application to WaterStone Foundation, your application will be reviewed by the Application Administrator, who will provide feedback regarding any missing or unclear information.
2. The Financial Aid Committee is comprised of members of the WaterStone Foundation board and clinical experts. The Committee reports directly to the WaterStone Foundation Board of Directors.
3. The Committee will review all applications and will make final decisions. Financial awards will be based on the following criteria:
    i. Financial need
    ii. Cost of recommended treatment plan
    iii. Urgency of need (based on treatment team recommendations and presenting information)
    iv. Commitment to treatment program and motivation to change
    v. Strength of support structure post treatment
4. If additional information is needed, the applicant (or parent/guardian) will be contacted by the Application Administrator.
5. Award amounts will be based on the criteria listed above, the number of applications, available funds and potential cost of treatment.
6. If resources are available, travel expenses may be reimbursed. Note that this form of assistance would only be provided on an exception basis.
7. Financial awards are distributed on a monthly schedule.
    - Applications received by 15th of month
    - Reviewed by Committee first week of following month
    - Financial assessment by 3rd week of same month
    - Applicants notified by end of same month
8. The Committee reserves the right to make any exceptions to the criteria as is deemed necessary.
9. Preference will be given to Canadian residents seeking treatment in Canada
10. The Financial Award expires 90 days from the estimated treatment start date but Applicant may reapply.
11. If an Applicant does not receive Financial Awards, they may reapply.
12. The Financial Award does not cover “no shows” or penalties incurred with the treatment provider.

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## Notification of Award

1. All applicants will be notified of the Financial Aid Committee's decision.
2. Applicants not receiving an award will not be notified of the reason behind the Application Committee's decision.
3. Each recipient will be notified via email and letter as soon as the decision has been made for award, with the amount of said award indicated.
4. An award letter will be mailed to the recipient and a copy will be emailed to the treating clinic or treatment provider.
5. Applicants not receiving an award will be notified by email and may reapply for the next quarter.

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# Application Form

**********

WaterStone Foundation and the Financial Aid Committee, will not use personal information for any reason other than to make determinations for financial assistance.

**********

All application sections should be typed directly into this form. Any text box can be made larger to accommodate your answers, When complete, please print the form, sign where indicated and submit it directly to:

WaterStone Foundation – Request Form
financialaid@waterstonefoundation.ca

**********

Before you begin, please be sure you have carefully read the application instructions. For all long form questions please use between 100-250 words to describe your answer. Please be sure your application fully addresses the four financial award criteria listed in item 3 on page 5. Provide as much detail as possible to show how you will effectively use the financial assistance sought.

**Section I: General Information**

| | |
|---|---|
| **Date Submitted** | |

**1. Applicant (Patient) Information**

| | |
|---|---|
| **Name** (First, Middle Initial, Last) | |
| **Date of Birth and Age** | |
| **Gender** | |
| **Street Address** | |
| **City, Province, Postal Code** | |
| **Home Telephone** | |
| **Cell Number** | |
| **Email** | |

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

| Name | Relationship to me | Age |
|---|---|---|
| | | |
| | | |
| | | |

3. **Please describe your employment or school.** (Include your occupation, the number of hours per week you work, your salary or hourly wage, and how long you have worked there or attended school.) Students please note the name of your school (or if you are home-schooled), what your grade/year 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 how you have tried to change the ways 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. **Use the table below to describe any of the behaviors that you have engaged in or experienced, either in the current day or in the past.**

| | Yes | No | How often on a weekly basis? | Last episode |
|---|---|---|---|---|
| Restricting | | | | |
| Bingeing | | | | |
| Purging | | | | |
| Anxiety | | | | |
| Depression | | | | |
| Dissociation (feeling separate from body) | | | | |
| Over Exercising | | | | |
| Using Laxatives | | | | |
| Using Diet Pills/Diuretics | | | | |
| Desire to cause self-harm | | | | |
| Other (describe) | | | | |

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

9. **What would you consider are your strengths for treatment?** In other words, what personality or other attributes will help you succeed in your treatment? Please be specific and give examples.

10. **What challenges do you anticipate in the process of your treatment? How do you plan to approach those challenges?**

11. **How would you define long-term success regarding treatment?** In other words, what is your hope for desired change while participating in this treatment clinic or with this treatment provider?

**Section III: Treatment History & Recommendations**

12. **Have you ever been hospitalized due to medical complications caused by your eating disorder?** 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.)

13. **Have you ever been treated at a residential clinic or hospital for eating disorders? If yes, please name the clinic and dates of treatment.**

14. **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:**

    B. **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?**

    C. **Please note anyone else you have seen as a part of your treatment team (nutritionist, primary care physician, and psychiatrist).**

| Role (nutritionist, etc.) | Name | Contact Information |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

15. **Include letters of recommendation from your primary therapist and other members of your treatment team (as noted above). If you have not yet received treatment, the in-take evaluation by the participating clinic will be required before the application will be evaluated. It is mandatory that at least one letter from a qualified professional be included as part of the application process, recommending the treatment that you are seeking.**

**Section IV: Post Treatment Support**

**Section V: Financial Information & How You Would Like WaterStone Foundation to Help You**

16. **Provide the name of the clinic you would like to attend and advise if you have an existing relationship or if this is a new relationship where an in-take assessment will be required.**

17. **We expect all applicants to contribute a minimum of 25% of the cost of their approved treatment plan. Please confirm that you are willing and able to make this contribution, contingent on the total cost of the treatment plan recommended.**

**Please note that the information provided will remain confidential. Only the program administrator and the RBC financial assessment administrator will see the individual's personal contact information. A unique ID will be created for each applicant to maintain confidentiality.**

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# SIGNATURE PAGE TO APPLICATION

I hereby certify that all information and attachments are true to my knowledge. I understand that false information may disqualify me from consideration for this award.

| _____ | _____ | _____ |
|---|---|---|
| Applicant Name | Applicant Signature | DD/MM/YY |

If the applicant is under 18, a parent or guardian must sign this application:

| _____ | _____ | _____ |
|---|---|---|
| Parent Name | Parent Signature | DD/MM/YY |

*Please submit ONLY the documents requested on this application.*