EDRS

EATING DISORDER RECOVERY SUPPORT

EDRS Treatment Fund Application for Providers

Name of Provider and Credentials:_____

License Number:_____

Governing Board:_____

Address:_____

State:_____ Zip Code:_____County:_____

Phone Number:_____

Email:_____

Name of Scholarship Applicant:_____

Age:_____ Gender Identification:_____

Type: □ Individual □ Group □Inpatient/Outpatient Program

Treatment Fund amount requested:

_____

To maximize the benefits of these funds, we require the administering provider to offer outpatient services at sliding scale rates. By signing this you agree to provide individual sessions at $100.00 per 50-60 minute individual session, and/or group therapy at $50.00 a session. NOTE: IF AN APPLICANT MISSES A SESSION THE FUNDS MAY NOT BE APPLIED TO MISSED APPOINTMENTS.

Are you willing to see the EDRS applicant on a sliding scale basis at $100.00 per session for 10 sessions or $50.00 per group for 20 groups □ yes □ no

How long have you been treating the EDRS applicant? In what capacity (eg groups, individual, IOP, Ext.)

_____
_____
_____
_____
_____
_____

Please give your response to why this applicant is applying and needs funds:_____

_____
_____
_____
_____
_____

What is the applicants ability and desire to engage in treatment like?

_____

_____
_____
_____

Areas of focus for the use of thisTreatment Fund:

_____

_____
_____
_____
_____
_____
_____

Applicants must have a diagnosis of an eating disorder, or be seeking assessment for one. The ERDS Treatment Fund Committee will provide funds upon approval, to the Provider. The Provider is responsible for reporting back to EDRS that the funds were used, or portions were used/unused, and the progress of the Treatment Fund recipient. Any unused funds are agreed to be returned to the EDRS Treatment Fund. Applications maybe mailed to the following address or email.

EDRS TREATMENT FUND Attention: Treasurer
911 Lakeville Street, Suite 217 Petaluma, CA 94952

Web page: **edrecoverysupport.org**

FOR OFFICE USE:

RECEIVED: _____ REVIEWED: _____

RESPONSE SENT:_____

AMOUNT APPROVED:_____ TYPE: _____

NOTES:_____

_____

I agree to all the terms and guidelines above.

Provider Signature:_____

Date:_____