Duke Diet & Fitness Center

DFC Endowment Fund
Application for Financial Aide

Eligibility

Applicants must meet the following criteria:

1) Minimum Body Mass Index of 30.
(see www.dukehealth.org/Services/DietAndFitness/Programs/FamilySupport for a BMI calculator)
2) Must be at least 18-years-old.
3) Recipient will be offered a two-to-four week program stay and will be expected to contribute one-third of the program cost (which will range from $1766.00 to $2625.00 depending on length of stay), plus all housing expenses (which will range from $789.25 to $1578.50 depending on length of stay).
4) Must demonstrate financial need.

Application Requirements

- ✓ **Complete and sign the five-page application.**
- ✓ **Write an essay of 400 words or less explaining how attending the DFC program will assist you in reaching your wellness goals. Please include past experiences with lifestyle change and weight loss efforts.**
- ✓ **Attach a copy of the first two pages of the last two years of your Federal Income Tax Return.**
- ✓ **Provide contact information for two references.**
- ✓ **Submit physician statement (as described on page five of the application).**
- ✓ **Finalists will complete a phone interview with a member of the DFC treatment team.**
- ✓ **Additional medical records may be requested.**

Personal Information

Name: _____
Address: _____
City: _____
State/Province: _____
Zip Code: _____
Country: _____
Home Phone: _____
Other Phone: _____ ❍ Cell ❍ Pager ❍ Beeper
E-mail: _____
Marital Status: _____
Date of Birth: _____
Do you live with anyone else? ❍ Yes ❍ No
If so, who? _____
Do you have children? ❍ Yes ❍ No
If so, please list their ages _____
Please describe your level of physical activity in a typical week _____
_____
_____

Please describe briefly the major adverse affects that you experience from excess weight._____
_____
_____
_____
_____

Please describe briefly what you consider to be the major factors contributing to your excess weight.
_____
_____
_____
_____

Emergency Contact

Name: _____ Phone Number: _____

Physician Information

Primary Physician Name: _____
Address: _____ Phone: _____
May we contact? ❍ Yes ❍ No

In order for us to contact the above listed physician, please complete a copy of the attached Authorization for Release of Medical Information form for each provider.

Employer Information

Are you employed at present? ❍ Yes ❍ No
If so, what is your occupation? _____
Employer Name: _____
Employer Address: _____
Employer Phone Number: _____
If you are not employed, is this due to health issues? ❍ Yes ❍ No
If no, what prevents you from working?
_____
_____

Medical Information

Please assess your general health: ❍ Excellent ❍ Good ❍ Fair ❍ Poor
If poor or fair, please explain_____
_____
_____

Your approximate weight in pounds or kilograms: _____

Your height in feet and inches or centimeters: _____

1. Have you been hospitalized for any reason within the past two to three years? ❍Yes ❍ No
If yes, please explain: _____
_____
_____

2. Personal History of cardiovascular disease (for example, have you had heart attack, stroke, transient ischemic attack (TIA), coronary artery bypass or CABG, angioplasty, stent placement, aortic aneurysm, peripheral vascular disease, angina or chest pain with exertion)? ❍ Yes ❍No
If yes, please explain_____
_____
_____

3. Regular tobacco use within the past year (daily use of cigarettes, cigars, pipe, or chewing tobacco)?
❍ Yes ❍No

4. Do you have elevated blood pressure (BP > 140 systolic, or >90 diastolic **OR** are you on medication for high blood pressure)? ❍ Yes ❍ No ❍ Not Sure

5. Do you have abnormal blood lipids (total cholesterol, triglycerides, HDL cholesterol, or LDL cholesterol) **OR** do you take cholesterol-lowering medication? ❍ Yes ❍ No ❍ Not Sure

6. Have either of your parents or a sibling (brother/sister) had blood vessel disease (heart attack, coronary artery bypass surgery, angioplasty, stent aortic aneurysm, peripheral artery disease, stroke, transient ischemic attack (TIA) at a young age (i.e. father or brother before age 55, mother or sister before age 65)?
❍ Yes ❍ No
If yes, please explain: _____

7. Do you have diabetes? ❍Yes ❍ No
Are you on any medication for diabetes? ❍ Yes ❍ No ❍ Unsure
If so, please list: _____
If you have diabetes, how well is it controlled? ❍ Very Well ❍Fair ❍ Poor ❍ Unknown

8. Have you had cardiac functional testing (for example, stress electrocardiogram, exercise tolerance test, or "treadmill" test, stress echocardiogram, nuclear cardiology test) within the past year? ❍ Yes ❍ No
If so, please submit results with your application.

9. Do you have heart disease other than those listed in # 2 above (for example, valve damage, rhythm disturbance, congestive heart failure)? ❍ Yes ❍No
If yes, please describe: _____

10. Do you need assistance walking, climbing stairs, or getting out of a chair or car?
❍ Yes ❍ No
If yes, please explain: _____
_____
_____

11. Do you use oxygen or an assistive device (cane, walker, wheelchair, electric scooter) to get around?
❍ Yes ❍ No
If yes, please explain_____

12. Have you ever vomited, used laxatives, or exercised excessively to compensate after overeating?
❍ Yes ❍ No
If yes, please explain: _____

13. Has anyone ever told you that you might have bulimia or anorexia? ❍ Yes ❍ No
If yes, please explain: _____

14. Do you believe, or has anyone else told you, that you might have a problem with drug or alcohol use?
❍ Yes ❍ No
If yes, please explain: _____

15. Name, dosage, and frequency of all prescription medications you are currently taking. _____
_____
_____
_____
_____
_____
_____
_____
_____
_____

16. Have you been diagnosed with or treated for a psychological or emotional problem within the past five years? ❍ Yes ❍ No
If yes, please explain: _____
_____
_____
_____
_____

How and when were you treated for this problem? Check all that apply and please list approximate dates and places for treatment.

❍ Outpatient psychotherapy/counseling
_____

❍ Psychiatric hospitalization
_____

❍ Other
_____

17. Please check any of the following that apply, indicate the extent to which you adhere to these dietary guidelines and what foods you are not able to eat.

❍ Vegetarian (avoid some animal products): _____
❍ Vegan (avoid all animal products): _____
❍ Kosher: _____
❍ Food Allergies: _____
❍ Other special dietary needs: _____

18. Other special needs (for instance: accommodating for translator services, impaired vision, hearing, mobility, or learning bility): _____
_____
_____

19. Please note your monthly income and expenses:

MONTHLY INCOME		**MONTHLY EXPENSES**	
Primary Job	$_____	Rent/Mortgage	$_____
Secondary Job	$_____	Vehicle Payments	$_____
Social Security	$_____	Utilities/Food	$_____
Other	$_____	Medical Expenses	$_____
Other	$_____	Other	$_____

ASSETS	Estimated Value		Estimated Value
Home site	$_____	Cash	$_____
Home site	$_____	Checking	$_____
Trailer	$_____	Savings	$_____
Rental property	$_____	IRA/Stock	$_____
Land	$_____	Life Insurance	$_____
Vehicle	$_____	Life Insurance	$_____
Vehicle	$_____		

Additional Information:
_____
_____

20. Approximately how much is the amount of your annual medical expense which you must pay "out of Pocket" (i.e., expenses that are not reimbursed by any form of insurance coverage?)
Amount: $_____

21. Please describe any financial burdens that would keep you from paying the normal fee for this type of program. (Please list all that apply) Be sure these expenses are noted under "other" in question #19.

a. Caretaker for loved one?
b. Child support?
c. Educational expenses?
d. Legal expenses?
e. Debt from other sources? Please list.

I recognize that I am applying for financial support from the Duke Diet and Fitness Center (DFC). I understand that the DFC may request additional information in order to review my application. The information provided is true and correct and is given to the best of my knowledge. I authorize release of my medical records and financial records related to my scholarship application to the DFC for the purpose of processing this application.

_____ _____
Signature **Date**

PHYSICIAN'S STATEMENT

Participant's Name: _____

Physician's Name: _____

Physician's Phone: _____

Your patient has submitted an application for scholarship assistance. A general medical evaluation of your patient and your assessment of how your patient will benefit from the Duke Diet and Fitness Center Program will help our financial aide Committee in their decisions. Please include comment on the following: mobility, cognitive limitations, motivation to pursue lifestyle change, known psychological issues, overall health, and compliance with recommended treatment.

Duke University Health System encourages individuals with disabilities to participate in its programs and activities. If you anticipate needing reasonable accommodations or have questions about the physical access provided, please contact Dina Lumia, at (919) 684-9746, in advance of your participation.

Fax your application to 1-919-684-8246 or mail to us at:

Duke Diet & Fitness Center
Attn: DFC Endowment Fund – Application Department
501 Douglas Street
Durham, NC 27705

You may also contact us for more information by e-mail at dfcinfo@mc.duke.edu or call us at 1-800-235-3853.

Authorization for Release of Medical Information

(Give this release to your doctor if he requests it. Permission to make copies granted.)

THIS FORM MUST BE COMPLETED IN FULL

Patient Name: _____

History #: _____

Date of Birth: _____/_____/_____

I authorize and request _____

(Name of doctor or hospital RELEASING information)

_____

(Address)

to release to **Medical Clinic, Duke University Diet & Fitness Center**

(Name of hospital or individual TO RECEIVE information)

804 West Trinity Avenue, Durham, NC, 27701-1826 *or fax to* (919) 688-8022

(Address)

Yes ☐ No ☐ medical information concerning the history, treatment, examinations, and/or hospitalizations for the periods from _____ through _____.

Yes ☐ No ☐ medical information pertinent to treatment for ( ) Alcohol ( ) Drug Abuse ( ) Psychiatric Care or ( ) Psychological Assessment and/or treatment for the periods from _____ through _____.

I understand this information will be used for _____.

I understand I may revoke this consent at any time except to the extent that action has already been taken on it, and that it will expire automatically ninety (90) days from the date indicated below. **NOTE: FEDERAL RULES PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION "UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED BY THE" WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR IS OTHERWISE PERMITTED BY 42 CFR PART 2**.

_____ _____

Signature of Patient Date

_____ _____

Signature of Patient's Legal Representative (if applicable) Witness

_____

Relationship to Patient