

Dear Scholarship Applicant,

The Culpeper Wellness Foundation has developed a Medical Needs Scholarship (FitScripts) for the purpose of financially supporting a limited number of individuals who have an identified medical need requiring ongoing participation in an exercise program. FitScript Scholarship candidates must demonstrate financial hardship and be committed to fully utilizing the Powell Wellness Center's services during the term of the scholarship.

Applicants must submit complete documentation as requested by Culpeper Wellness Foundation including, but not limited to:

- (1) **Completed** Culpeper Wellness Foundation Scholarship Application (Attachment I),
- (2) **Completed** Documentation of Medical Needs (Attachment II), and
- (3) **Completed** Documentation of Financial Hardship including proof of income (Attachment III).
- (4) FitScripts Referral Form from physician.

For full consideration, the entire application must be submitted with proper proof of income. Culpeper Wellness Foundation reserves the right to require further documentation as deemed necessary. All medical records and financial documentation will be treated as confidential.

The term of an approved scholarship will not exceed a period of two months. If the scholarship is awarded, you will participate in the Powell Wellness Center's Fitscripts Program, which includes 16 supervised exercise sessions and access to facility during the 8 weeks. After successful completion of the FitScript program, you will have the opportunity to convert into a membership and receive 70% off your enrollment fees. Ongoing medical scholarships are valid for 1 year from start of the FitScript program and are reviewed for renewable every three months based on facility visits of at least 8 times per month on average for the term of the scholarship.

Funding applications will be reviewed on an as needed basis and will be subject to a **2-4 week** processing time frame. Every effort will be made to expedite the review process. Funding requests, which are not approved, may be resubmitted no earlier than three months after the date of the original application.

If you have any further questions about the Culpeper Wellness Foundation Medical Needs Scholarship please feel free to contact me at 540-445-5390.

Sincerely,

Eric Good

Eric Good, FMFA / Director Powell Wellness Center

egood@culpeperwellness.org

540-445-5390

Enclosures



Attachment I

Culpeper Wellness Foundation
Medical Needs Scholarship Application

Name: _____ Date: ____/____/____

Home Address: _____

City: _____ State: _____ Zip: _____

Birthdate: ____/____/____ Social Security Number: ____ - ____ - ____

Employer: _____ Employer Contact (supervisor): _____

Employer Contact: _____ (supervisor)

Referring Physician: _____ Phone Number: _____ Fax Number: _____

Medical Diagnosis: _____

Desired Program of Activity: _____

Benefits you hope to gain: _____

Goal Participation Level (days per week): _____

Additional Comments for consideration:

Medical Information Release Authorization: I hereby release any and all medical records necessary to complete the application for Culpeper Wellness Foundation Scholarship. I understand that all information will be treated as confidential.

Applicant Name (printed): _____

Applicant Signature: _____

Attachment II

Culpeper Wellness Foundation
Scholarship Applicant
Documentation of Medical Needs

Medical Need: All Culpeper Wellness Foundation Scholarship Applications will require documentation of their medical condition with their personal physician and/or referring physician's signature. ***If participating in the FitScript program, the FitScript Referral form will serve as documentation of medical need.*** All medical information will be treated as confidential information.

FitScript Referral Form Attached? _____

Medical Needs/Diagnosis:

Date of Original Diagnosis: _____

Nature of Need/Benefit:

Please list any exercise restriction or recommendations:

Physician's Signature

Date



Attachment III

Culpeper Wellness Foundation
Scholarship Application
Documentation of Financial Hardship

(Must be completed by applicant)

Financial Hardship

Annual Household Income last two years (**must include your income and your spouse's income**):

2016 \$ _____ **2017** \$ _____

You must provide documentation to support above information. A copy of your income tax return is required as proof of income. If you did not file a tax return, a copy of your social security statement must be provided along with all other applicable income statements. Applications without proof of income attached will not be considered.

Income Source(s): (**must check all that apply**)

- Salaries and Wages
- Social Security Benefits
- IRA Distributions
- Pensions and Annuities
- Dividends
- Unemployment Compensation
- Child Support
- Other: please explain: _____

Number of dependents per household: (**must check all that apply**)

- Yourself
- Spouse
- Dependents (how many): _____

(Dependents listed must match information on income tax return)

I hereby affirm that this information is accurate and complete to the best of my knowledge.

Applicant Signature: _____

Date: _____

Medical Needs Scholarship Addendum

As a recipient of the Medical Needs Scholarship, I understand that this **8 Week Program** Powell Wellness Center membership is awarded to a limited number of candidates who meet the established criteria. I am committed to fully utilizing the programs and services available through this membership, and will use the facility at least two (2) or more times a week.

If I become unable to use this membership due to medical reasons or other uncontrollable circumstances, I understand it is my responsibility to notify Culpeper Wellness Foundation as soon as this occurs.

I understand that this Medical Scholarship if approved is effective for an initial 8 weeks through the FitScript program. Upon successful completion of the FitScript program, I will have the option to join Powell Wellness Center as a Medical Scholarship Membership provided I pay the enrollment fee at a discount of 70% off the regular fee. Medical Scholarship Memberships are effective for 1 year from the initial FitScript program start date(intake appointment) subject to renewal every 3 months based on facility usage. A Medical Scholarship membership may be extended on an annual basis provided a completed application along with updated proof of income is provided.

By my signature, I fully accept the terms and conditions of the Culpeper Wellness Foundation Medical Needs Scholarship Membership.

Applicant Signature

Printed name

____/____/____
Date

For Office Use Only

Application Received: _____
 Proof Of Income attached: ___yes ___no
 FitScript Referral Form attached: ___yes ___no
 Medical Scholarship Approved: ___yes ___no
 Medical Scholarship Declined On: ___/___/___ reason: ___application incomplete ___ income too high
 Applicant Notified: ___/___/___