Duke Diet & Fitness Center

DFC Assistance Fund Grant
Application for 2018

Eligibility

Applicants must meet the following criteria: 1) minimum Body Mass Index of 35 (see http://www.nhlbi.nih.gov/guidelines/obesity/BMI/bmicalc.htm for a BMI calculator 2) must be at least 25-years-old 3) recipient will be offered a four week program stay 4) recipient will be offered a $6,885 grant towards a four-week program 5) must demonstrate financial need 6) must attend the program within three months of acceptance

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 your most recent U.S. Income Tax Return.**
- ✓ **Provide contact information for two references**
- ✓ **Submit physician statement (as described on page five of the application).**
- ✓ **Complete a phone interview with a member/s of the DFC treatment team.**

Personal INFORMATION

Name:_____
Address: _____
City:_____
State/Province_____
Zip Code: _____
Country:_____
Home Phone:_____
Other Phone:_____ o cell o work
E-mail:_____
Marital Status:_____
Date of Birth:_____
Do you live with anyone else? O Yes O No
If so, who?_____
Do you have children? O Yes O No
If so, please list their ages_____
Please describe your level of physical activity in a typical week_____
_____

Please describe the major adverse affects that you experience from excess weight_____
_____
_____
_____

Please describe what you consider to be the major factors contributing to your excess weight_____
_____
_____

Emergency Contact
Name:_____ Phone Number: _____

Physician Information
Please list names and contact information and indicate whether you give these health care providers permission to share your health-related information with us:

Primary Physician Name:_____
Address:_____Phone:_____
May we contact? O Yes O No
If you would like us to contact additional providers, please complete a copy of the attached Authorization for Release of Medical Information form for each provider.

Employer Information
Are you employed at present? O Yes O 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? O Yes O No
If no, what prevents you from working?
_____
_____

MEDICAL INFORMATION
Please assess your general health: O Excellent O Good O Fair O 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? O Yes O No
If yes, please explain:_____

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

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

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

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

6. Do you have a history within your immediate family of early heart disease (father or a brother who has had a heart attack or sudden cardiac death before age 55, or mother or a sister who has had this before age 65)? O Yes O No

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

10. 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, or TIAs) **at a young age** (i.e. father or brother before age 55, mother or sister before age 65)?
O Yes O No If yes, please explain:_____

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

12**.** 11. Do you need assistance with getting to the bathroom, dressing or bathing?
O Yes O No If yes, please explain:_____

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

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

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

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

17. Name, dosage, and frequency of all prescription medications you are currently taking._____
_____
_____
_____
_____
_____
_____
_____
_____18. Have you been diagnosed with or treated for a psychological or emotional problem within the past five years? O Yes O 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, the names and contact information for recent providers, and a brief description of treatment.

O Outpatient psychotherapy/counseling

O Psychiatric hospitalization
_____

O Other
_____

19. In order to provide you with the best possible care, we may need to speak with or obtain records from your doctor or mental health providers prior to your acceptance into the program. Please sign below to indicate your permission to do so. **(*If you would like us to contact additional providers, please complete a copy of the attached Authorization for Release of Medical Information form for each provider)***

Signature:_____ Date:_____

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:_____

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

21. 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**		
Homesite	$_____	Cash	$_____
Homesite	$_____	Checking	$_____
Trailier	$_____	Savings	$_____
Rental property	$_____	IRA/Stock	$_____
Land	$_____	Life Insurance	$_____
Vehicle	$_____	Life Insurance	$_____
Vehicle	$_____		

Additional Information:
_____
_____

22. 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_____.

23. 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 #21.

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

23. If awarded with a scholarship, when would you like to come? (***Please note scholarships must be used within three months of acceptance notification. New client programs begin on Mondays each week.)***
First Choice: _____ Second Choice _____

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 grant application to the DFC for the purpose of processing this application. If accepted, you may be asked to participate in promotional materials for the DFC Assistance Fund Grant.

_____ _____
Signature Date

Please have your physician provide the following statement and include with your application:

PHYSICIAN'S STATEMENT

Participant's Name:_____

Physician's Name:_____

Physician's Phone:_____

Your patient has submitted an application for a scholarship grant. 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 aid 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 (800)235-3853, in advance of your participation.

Fax your application to 1-919-688-3295 or email to us at dfcapps@dm.duke.edu or mail to us at:
Duke Diet & Fitness Center
Attn: DFC Assistance Fund Grant– Application Department

501 Douglas Street
Durham, NC 27705
You may also contact us for more information by e-mail at
dfcinfo@dm.duke.edu or call us at 1-800-235-3853.