

WithAll Recovery Support Program Application Preview

1. Do you have a current eating disorder diagnosis from a medical professional?
Yes/No
*****You must have a current diagnosis to be eligible for this grant.**

Applicant Information

1. First Name
2. Last Name
3. Mailing Street
4. City
5. State
6. Zip Code
7. Date of Birth
8. Phone Number
9. Email Address
10. Gender identity (optional):
11. Ethnicity (optional):
12. If awarded, I agree to fill out a survey 2 months after award date: (check box to agree)
13. How did you hear about WithAll? Treatment Team, Social worker, Friend or Family, Internet, Other (please specify)
14. I would like to be added to WithAll's email and mailing list (your answer will not affect your award eligibility). Yes/No

Answer all the questions below in order to be considered for a grant. Please note that certain questions determine your eligibility. If you are ineligible, you can cease filling out the application.

Application Questions

1. How many hours per week are you in the treatment program?
2. What type of intensive treatment are you currently in or seeking? *You must be in an intensive program to be eligible for this grant. Please note that WithAll defines "intensive treatment" as at least 9 hours a week.*
 - a. Residential
 - b. Intensive Outpatient
 - c. Partial Hospitalization
 - d. Other
3. What is your anticipated length of treatment in weeks? (If you are unsure, please enter your minimum or best estimate):

To receive a grant, we must have proof from one of your treatment providers that you are participating in an intensive treatment program. Please complete the following:

- Treatment Program Name (ex: Melrose Center, The Emily Program, etc.)
- Therapist's Name:
- Therapist's Email Address:
- Therapist's Phone Number (if you do not have your therapist's phone number, please provide your treatment program phone number):

Expense Needed:

1. What expense is your biggest financial stressor? (Please choose **one** of the following to apply for assistance): Transportation, Groceries, Rent/mortgage, Daycare

2. If you chose groceries, what is your anticipated weekly cost of groceries for your household?
 - a. How many people are you responsible for providing groceries in your household (including you)?

3. If you chose transportation, what is your anticipated weekly cost for transportation?

Document Upload

Please upload a recent statement/bill related to the expense you selected above (if attaching a bank statement, please exclude any bank account number or identifying information): *Upload a PDF, Word Doc, JPG, etc.*

To help us understand:

1. What are the barriers and challenges you face as you work to pursue treatment?
2. What is your specific financial situation - why are you applying for this grant?