Eating Disorder
Recovery Support

Name of Provider and Credentials:____

License Number:______________ Governing Board:___________________________

Address:____State:________

Zip Code:___________________ County:_____________________________________

Phone Number:_______________________ Email:____________________________

Name of Scholarship Applicant:____

Type: ☐ Individual ☐ Group

Scholarship Amount Requested:

____

To maximize the benefits of this scholarship, we require the administering provider to offer outpatient services at sliding scale rates. By signing this you agree to provide individual sessions at $50.00 per 50 minute individual session, and/or group therapy at $25.00 a session. NOTE: IF AN APPLICANT MISSES A SESSION THE SCHOLARSHIP MAY NOT BE APPLIED TO MISSED APPOINTMENTS.

Are you willing to see the EDRS Scholarship Applicant on a sliding scale basis at $50 per session for 10 sessions or $25 per group for 20 groups ☐ yes ☐ no

How long have you been treating the EDRS Scholarship Applicant and in what capacity (eg groups, individual, IOP,Ext.____

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Please give your response to why this applicant is applying and needs this scholarship:____

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Services and Modalities That Will Be Used:___________________________________

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Symptoms and Behaviors To Be Focused On (Please rate on a scale 0-10/ten being the most):____

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Applicants Willing to Engage in Treatment:___________________________________

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I agree to all the terms and guidelines above.

Provider Signature:_________________________________ Date:_______________