Frazier Rehabilitation Institute

UofL Health

# Community Fitness and Wellness Scholarship Application

## General Information and Deadlines

Scholarships will cover ONE guided exercise activity a week or a basic gym membership. A basic gym membership is included in all scholarship awards that request a guided exercise activity**.**

The following eligibility criteria must be met to participate in the scholarship program:

- Applicants **must have a disabling condition**.
- Applicants cannot have outstanding unpaid fees.
- Applicants are required to complete a conference with the CFW supervisor to review their scholarship application and discuss additional details regarding the request.

Eligibility to receive a scholarship will be considered **after** the following are submitted:

- ☐ Complete membership application
- ☐ Doctor's medical release
- ☐ Scholarship application
- ☐ Veterans ID *(if applicable)*

Completed applications can be submitted via mail, fax, e-mail, or in-person:

- **Address:** Community Fitness and Wellness
  250 E. Liberty Street, Suite 100
  Louisville, KY 40202
- **Fax:** 502-587-4512
- **E-mail:** CFW@UofLHealth.org

Please direct any questions to Community Fitness and Wellness at (502) 582-7411.

## Financial Assistance Information

- Assistance is for **3 months** and should not be relied upon beyond the scholarship period.
- Funding is limited. Assistance will range from 100% to 25% of fees.
- Funding will be awarded to those with the greatest need. Those who have never received services or assistance in the past will receive the highest priority.
- Assistance will be available on a sliding scale and based upon need. Need is determined by household size and income.
- **VETERANS** with disabilities will be awarded one 3-month scholarship period. Thereafter, eligibility for additional scholarship will be determined by household size and income.

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UL Health

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## Applicant Information

**Member Name:**

**Address:**

**City:** **State:** **ZIP:**

**Phone Number:** **E-mail Address:**

**Alternate Contact:** **Phone Number:**

**Diagnosis:** ☐ Spinal Cord Injury ☐ Brain Injury ☐ Stroke ☐ Amputation
☐ Parkinson's Disease ☐ Spina Bifida ☐ Developmental Disability
☐ Other (please describe): _____

**Veteran Status:** ☐ Yes ☐ No *(must provide a copy of ID)*

## Activity Selection and Scheduling Preferences

Scholarship requests will cover ONE of the following options. Please indicate your choice below.

☐ Guided Exercise (60 minutes, 1-on-1 with trainer).
☐ Functional Electrical Stimulation (FES) Cycling – Legs (60 or 90 min. incl. set-up).
☐ Functional Electrical Stimulation (FES) Cycling – Arms (60 min. incl. set-up).
☐ Neuromuscular Electrical Stimulation (NMES) w/activity (60 min).
☐ Basic Gym Membership Only: independent use of gym during business hours (Mon – Fri).
☐ Please contact me. I need help deciding.

Which days of the week do you prefer *(select all that apply):*

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Which time of the day do you prefer *(select all that apply):*

☐ 8:00-9:00 ☐ 9:00-10:00 ☐ 10:00-11:00 ☐ 11:00-12:00

☐ 12:00-1:00 ☐ 1:00-2:00 ☐ 2:00-3:00 ☐ 3:00-4:30

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## Cancellation & Attendance Policy

Applicants who are awarded a scholarship must agree to the following:

- Attend all scheduled sessions and follow the CFW cancellation policy including:
    - Cancel sessions via phone with plenty of notice; at the latest by 2:00 pm on the day before your scheduled appointment.
    - Provide notice and an adequate reason for missing the appointment (e.g., sickness, transportation problems).
- Understand that chronic tardiness and failure to abide by cancellation policy may result in loss of assistance.
- Understand that **two (2) no show/no calls will result in the loss of assistance**.
- Basic Gym Membership recipients must attend at least once a week to maintain the scholarship.

## Membership Agreement

I, _____(*print name*), in consideration of receiving assistance with Community Fitness and Wellness fees, and intending to be legally bound, state and agree to the following:

1. **Cancellation & Attendance Policy: I understand and agree to follow the CFW cancellation and attendance policy.**

   _____ _____

   Member signature Date

2. **Representations and Warranties. In order to receive assistance with CFW fees, I hereby represent and warrant to the CFW that:**

   a. I have a disabling condition: ☐ YES ☐ NO

   b. My household includes (enter number of) _____ adults, and _____ dependents.

   c. My monthly household gross income* equals _____

   d. I pay out-of-pocket for personal care attendant $_____ per month.

   f. I pay out-of-pocket for transportation costs, including Ky Assistive Tech loan payment for modified vehicle, $_____ per month.

   e. There are ____ / are not_____ additional resources (example: grant awards, gifts from family, friends, etc.) that are available to assist me with membership fees? _____

   **Initial**

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UofL Health

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*__Household gross income__ means the income of every person who will contribute to payment of fees in the member's household (e.g. parents, spouse, etc), including earned income (wages or self emp) child support, government benefits (social security, SSD, SSI), military family allotment, strike benefits, unemployment comp, workers comp, investment income (dividends, rental income, etc.), alimony, pension income, disability insurance, and VA benefits.

3. **I agree to repay any and all assistance received if I have knowingly and materially provided false information.**

_____ _____

Member signature Date

## Affidavit of Member or Member's Guardian

I, _____(print name), have personal knowledge of the information provided on the foregoing page entitled Frazier Rehab Community Fitness and Wellness Facility's Membership Assistance Program Eligibility Form, Agreement, and Affidavit, and I affirm under penalty for perjury that all of the foregoing information regarding my (or my ward's) household size and gross income is true as of the date provided.

_____ _____

Member or Guardian's signature Date

**Administrative Use Only:**
Application received on: _____