Endometriosis Foundation of Houston
Healing Hou Scholarship Program Application

REQUIREMENTS

Please submit the following REQUIRED documents along with this completed application via email to healinghou@gmail.com by December 31, 2024.

REQUIRED - **Personal story**: We want to know your journey with endometriosis (250-500 words). Where are you now with your endo journey? We want to know who you are – hobbies, profession, family history, why you would be a worthy candidate. You are encouraged to tell the committee why you think you need a scholarship and why they should present the opportunity to you.

REQUIRED - Copy of most recent household tax return **OR** copy of the last two (2) pay stubs. If self-employed, please provide a self-employment letter confirming occupation type and monthly gross income. If unemployed, a copy of any financial award letters from disability, social security, or unemployment offices. **PLEASE BLACK OUT/REDACT YOUR SOCIAL SECURITY NUMBER ON ANY DOCUMENTS YOU SUBMIT.**

REQUIRED – Copy of government issued identification. Applicants must be at least 18 years of age.

REQUIRED – Application form: The entire application form herein, including release form and compliance form. Incomplete applications will not be considered.

DEADLINE: Applications must be received by EFHou by the deadline date of **December 31, 2024**. No late submissions accepted. Once you have completed the application, please email it and supporting documents to us at **healinghou@gmail.com** with the subject line **"2024 Healing Hou Application."** We will only accept applications submitted via email.

INTERVIEW: Finalists will be asked to attend an interview via Zoom in January 2025. Decisions will be made by February 1, 2025.

Appointments: Recipients MUST initiate contact with their clinician by March 1, 2025.

For questions regarding the EFHou Healing Hou Scholarship Program, please contact:
Etni Flores, Program Director at healinghou@gmail.com.

Endometriosis Foundation of Houston
Healing Hou Scholarship Program Application

Please email the complete application to us at **healinghou@gmail.com** with the subject line **"2024 HEALING HOU APPLICATION"**.

1. BASIC INFORMATION

Applicant Name: _____ Date: _____
(First Name Last Name)

Birth Date (MO/DD/YY): _____
Email: _____
Home Phone: (_____)_____
Cell Phone: (_____)_____
Address Street: _____
City: _____ State: _____ Zip Code: _____
County of residence: _____

Optional:

Race: ☐ White ☐ Black/African American ☐ Hispanic/Latin ☐ Asian
☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other _____
Gender identity: _____

2. ENDOMETRIOSIS

How did you hear about EFHOU? _____
Have you been diagnosed with or suspect you have endometriosis? _____
Please explain:

_____

_____

What have you tried in order to manage endometriosis symptoms?

_____

_____

Who is the physician managing your endometriosis care? _____

3. HEALTH INSURANCE

Do you have health insurance?

☐ NO

☐ YES Name of Company: _____

Please answer if applying for PFPT Scholarship

Do they pay for PT services? ☐ YES ☐ NO

Do you have a copay/coinsurance for PT services? ☐ YES ☐ NO

Copay/coinsurance amount? _____

Please answer if applying for Mental Health Scholarship

Do they pay for outpatient mental health services? ☐ YES ☐ NO

Do you have a copay/coinsurance for mental health services? ☐ YES ☐ NO

Copay/coinsurance amount? _____

What is the annual out of pocket max? $_____

What is the annual deductible amount? $_____

Do you expect to meet your 2025 deductible? ☐ YES ☐ NO

4. FINANCIAL

All financial information provided will remain confidential. Financial need will play a role in determining scholarship recipients.

We require a copy of the first page of your most recent federal tax return OR two (2) recent pay stubs.
NOTE: Please black out/redact your social security number on any documents you submit.

Applicant Annual Income: _____

Annual Household Income (if different): _____

Select one:

☐ Employed ☐ Unemployed Since _____ ☐ Retired Since _____

☐ Permanent disability Since _____ ☐ Active Military Since _____

Total number of persons in household: _____

Total number of wage earners in household: _____

Total number of dependents in household: _____

Please list the amount of your total monthly expenses: Total _____

Optional:

Rent/Mortgage_____ Utilities_____ Telephone _____ Food_____

Car _____ Other _____

Are you solely responsible for your medical care expenses? Do you receive assistance from another person in your household?

_____

_____

Is there any other information you would like us to consider while reviewing your financial information?

_____

_____

5. <u>PHYSICAL THERAPY (Please skip this section if ONLY applying for the mental health scholarship)</u>

A referral is required for physical therapy from your physician. Will you be able to obtain a referral?

☐ YES ☐ NO

Are you currently in pelvic floor physical therapy? ☐ YES ☐ NO

Have you ever had pelvic floor physical therapy? ☐ YES ☐ NO

If so, who is/was your physical therapist? _____

If so, please tell us about this experience.

_____

_____

If you are **NOT** currently in pelvic floor physical therapy, what are the barriers to care? What is preventing you?

_____

_____

If you **ARE** currently in pelvic floor physical therapy, what have been your biggest challenges?

_____

_____

What are your goals for physical therapy? What do you want to get out of this opportunity?

_____

_____

Realistically, how much time are you able to devote to doing PT homework each week?

_____

What would prevent you from fully participating in physical therapy if you were awarded this scholarship?

_____

_____

Do you have reliable transportation to appointments?

_____

Dr. Tessa Matus sees patients Tuesday through Friday, primarily from 9-3. Some early mornings are available. Please list all of your availability during these times.

_____

_____

6. **<u>MENTAL HEALTH THERAPY (Please skip this section if ONLY applying for the PFPT scholarship)</u>**

Are you currently seeing a mental health therapist? ☐ YES ☐ NO

Have you ever had mental health therapy? ☐ YES ☐ NO

If so, who is/was your therapist? _____

If so, please tell us about this experience.

_____

_____

If you are **NOT** currently in mental health therapy, what are the barriers to care? What is preventing you?

_____

_____

If you **ARE** currently in mental health therapy, what have been your biggest challenges?

_____

_____

What are your goals for therapy? What do you want to get out of this opportunity?

_____

_____

Realistically, do you feel ready to do the work of therapy?

_____

_____

What would prevent you from fully participating in therapy if you were awarded this scholarship?

_____

_____

Bianca Asteris sees patients Monday and Thursday evenings, Saturday mornings, and Monday through Thursday 10 am - 1 pm. Please list all of your availability during these times.

_____

_____

The following documents must be attached to this application:

1. First page of your latest federal tax return OR 2 recent pay stubs (**black out/redact social security number**)
2. Patient Compliance Form
3. Personal story (see attached for instructions)
4. Copy of driver's license or government issued identification card.

Deadline: December 31, 2024

Agreement

I understand that I may be asked to participate in an interview via Zoom in January 2025 if I am selected as a finalist.

☐ YES ☐ NO

I understand that the scholarship provides up to 12 sessions, which are intended to support me in making progress but may not address all of my needs. I understand that these 12 sessions are a valuable starting point to help me gain tools, resources, and guidance to manage endometriosis, but further treatment may be needed beyond the scholarship's scope.

☐ YES ☐ NO

I am confirming that I live in Texas permanently and the information listed above is accurate to the best of my knowledge. I understand that if I qualify as an EFHou Healing Hou Scholarship Program recipient, my status as a Scholarship Program recipient may be IMMEDIATELY revoked if any evidence of fraud or misrepresentation of my diagnosis and financial status is uncovered.

_____ _____

Applicant's Signature Date

_____

Applicant's Name (print)

Endometriosis Foundation of Houston
Healing Hou Scholarship Program

Patient Compliance Form

I, _____ (print patient name), understand if accepted for EFHou assistance, I must comply with the following terms or I shall be terminated from the program:

1. Show up on time. Please be respectful of the provider's schedule as they also have a private practice with other scheduled appointments.
Patient Initials: _____
2. Avoid cancellations. If you are unable to attend your appointment for whatever reason, you must contact your therapist's office to reschedule a minimum of twenty-four (24) hours in advance. Failure to do so will result in forfeiting the session.
Patient Initials: _____
3. Adhere to your provider's clinical policies and rules of treatment. You must follow your therapist's policies and rules of treatment through the entirety of your scholarship, including attending all scheduled appointments, participating in a home program if applicable, and follow through with all treatment plans. Scholarship status may be terminated due to excessive cancellations at provider's discretion.
Patient Initials: _____
4. Patient is responsible for transportation and lodging, if needed. Physical therapy sessions will be held in Bellaire for the pelvic floor physical therapy scholarship or virtually for the mental health scholarship. Scholarship recipients are responsible for their own transportation to and from appointments and local lodging, if needed. No special accommodations will be made.
Patient Initials: _____
5. If you and the therapist determine together that the treatment is not a good fit for you at this time, you may withdraw from the Scholarship Program and forfeit the remainder of your sessions.
Patient Initials: _____
6. You understand that mental health and pelvic floor physical therapies can be emotionally triggering for some people and you feel psychologically prepared to participate in these sessions.
Patient Initials: _____
7. Per Texas state law, you will be required to obtain a referral for pelvic floor physical therapy from a physician or chiropractor. A referral is not needed for mental health therapy.
Patient Initials: _____

8. Scholarship recipients will be announced by 02/01/2025. Scholarship recipients are required to schedule an appointment **within one (1) month** of award and finish treatment by **September 1, 2025**. Patient Initials: _____

Please note that the Endometriosis Foundation of Houston pays for up to twelve (12) sessions on your behalf based on your individual treatment plan.

I have read, understand, and agree to comply with this policy. I understand if I fail to comply with the above mentioned policies, my scholarship status shall be terminated.

_____ _____

Patient's Signature Date

_____

Patient Name (print)

Endometriosis Foundation of Houston
Healing Hou Scholarship Program

Informed Consent and Acknowledgement of Risk

IN CONSIDERATION for the opportunity to apply for participation in the EFHou Healing Hou Scholarship Program, the undersigned applicant understands and agrees that:

1. There is some risk in undergoing these treatments, including but not limited to a temporary increase in patients' current level of pain, discomfort, or an aggravation of their existing symptoms. Undergoing pelvic floor physical therapy or mental health therapy may be physically or emotionally uncomfortable for some patients.

2. Patient assumes all risk of and financial responsibility for any loss or injury related directly or indirectly to participation in the program and agree to indemnify and hold EFHou harmless from and against any and all costs, claims, demands, charges, liabilities, obligations, judgments, executions, costs of suit and actual attorneys' fees incurred or suffered by the applicant as a result of, or arising out of, the applicant's participation in the EFHou Healing Hou Scholarship Program except for claims resulting wholly from the gross negligence of EFHou;

3. EFHou itself is not a medical expert or provider of any medical services and makes no determination as to whether this program is advisable or appropriate for anyone; participation in this program is voluntary and participants in the program agree to evaluate the risks of participating in the program independently and with the aid of their personal medical professionals to determine if the program is appropriate for them and their medical and personal needs;

4. All aspects of the program including without limitation the services donated, the criteria for participation, the application and review process and the methods used to publicize the program are subject to change at anytime, without notice, in EFHou's sole discretion based on the availability of donated services, funding and the best interests of EFHou and the public;

5. The therapists, clinics and others donating medical services for this program may require additional consents and releases prior to allowing applicants selected by EFHou to participate in the program and receive treatment; and,

6. This agreement shall be construed and interpreted in accordance with the laws of the State of Texas without regard to its conflicts of laws provisions and agree further to the submission of any dispute under this agreement or the EFHou Healing Hou Scholarship Program as a whole to Federal or Texas courts located solely within the State of Texas.

7. Any questions or issues concerning the interpretation of this agreement shall be first resolved through local mediation, and if mediation is unsuccessful, the parties agree that all claims will then proceed solely through the courts located in the jurisdiction of Harris County.

This Informed Consent and Acknowledgement of Risk shall not be amended, supplemented or abrogated without the written consent of EFHou. The undersigned applicant has read and understands the content of this Informed Consent and Acknowledgement of Risk and executes this agreement freely and voluntarily.

_____ _____

Patient's Signature Date

_____

Patient Name (print)