GAUDIANI CLINIC

Expert Medical Care for Eating Disorders

Aaron's Gift Scholarship Application Process

This document was created to clarify the process for those seeking an Aaron's Gift Scholarship for care provided at the Gaudiani Clinic.

Step 1:
Determining eligibility:

☐ Do you (or have you) struggled with an eating disorder and/or disordered eating?
☐ Do you reside in one of these 33 states: AZ, CA, CO, CT, FL, GA, IA, ID, IL, IN, KS, KY, MD, ME, MI, MN, MS, MT, NC, ND, NH, NY, NV, OH, OK, RI, SD, TN, TX, UT, WA, WI, or WY?
☐ Do you have a commercial PPO/EPO insurance plan (or have Kaiser or Medicare with an in-network MD who will partner with us)? *We are unable to support folks with an active Medicaid Plan.*
☐ Can you afford our associated reduced fees of $250 expert consultation, $250 one year membership fee, and $50 per 25 minute follow-up session? *Frequency of follow-up appointments are individualized.*
☐ Do you have access to $80,000/year or less through income and savings within your family/household?
☐ Do you choose to proceed with the scholarship, noting that it lasts up to one year only, and we cannot make extensions (even for really good reasons)? *This timeline for care may not suit all. Please check in with yourself before applying.*

If you've said yes to the above criteria, please proceed with the application.

Step 2:
Please complete the following and provide to the Gaudiani Clinic (info@gaudianiclinic.com) for review:

☐ Attached Aaron's Gift Application, including:
- ☐ Intake form
- ☐ Aaron's Gift questionnaire
- ☐ Release of information for Aaron's Gift
- ☐ Releases of information for current/recent care providers (e.g., therapist, dietitian, PCP)
- ☐ Financial needs statement

☐ Financial Information
- ☐ Most recent W2
- ☐ Most recent three paystubs

☐ Referral letter from a current provider. *Any provider can complete this. It can be a brief document sharing some of your work together, what you've been up against, and how a scholarship could help. This can be emailed to the Gaudiani Clinic directly from the provider info@gaudianiclinic.com.*

All of the above-listed information must be completed and submitted by the due date in order to be considered. Incomplete packages will not be accepted.

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Step 3:
The Gaudiani Clinic will review all completed applications received and select applicants to proceed with the scholarship process who are deemed the best clinical fit with prioritization for those who exist in marginalized identities and bodies. You will be notified of your application status upon completion of this initial review. For those selected to proceed with the scholarship process, the Gaudiani Clinic will forward along portions of your application and our own letter of support to the Aaron's Gift Board for their final review and approval. Aaron's Gift will then reach out to you and/or your financially responsible party/guardian with an award or declination letter and fee structure. The Gaudiani Clinic will be copied on this email. This process may take up to 4 weeks to complete.

Step 4:
Once the Gaudiani Clinic has received the award letter from Aaron's Gift, we will confirm receipt and let you or your financially responsible party/guardian know that you have two weeks from that date to accept the award and complete all consents and other paperwork for the clinic. If these tasks have not been completed within two weeks, the award will be forfeited. The required paperwork is outlined below and will be sent to you and the financially responsible party/guardian via our e-sign platform:

☐ Consents package
☐ Aaron's Gift award letter and fee agreement (signed by patient and financially responsible party)
☐ Scholarship duration reminder form & consent
☐ Credit card form

Step 5:
Once we have received all of the required paperwork outlined above, we will reach out to you and/or your financially responsible party/guardian to schedule the expert consultation and send any orders for labs or additional studies that the physician may want in advance of that visit. Failure to schedule and complete an expert consultation promptly may result in the loss of the financial assistance award.

Should you have any questions or concerns, please feel free to reach out.

Warmly,
Gaudiani Clinic Team

Please note that the Gaudiani Clinic and Aaron's Gift align in their mutual goal to provide access to expert medical care to patients who are struggling or who have struggled with an eating disorder or disordered eating. Outside of this goal, the views, beliefs, and opinions that are expressed by Aaron's Gift are solely those of the organization and do not necessarily represent those of the Gaudiani Clinic and its employees.

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Intake Form

The purpose of this form is for us to learn key information about your goals and medical concerns. We will review this in order to get a sense for how and whether the clinic might be helpful and to know what testing might need to be performed prior to a first visit. This information also allows us to start getting to know you as a whole person, which is one of the top values of the clinic. You will have the opportunity to discuss all of these topics in much greater detail during your initial consultation. Please feel free to not answer any questions you feel are harmful or irrelevant and add any information you feel would be useful for us to have.

Demographics

Patient name: **Patient legal name (if different):**

Date of birth: **Sex assigned at birth:** **Pronouns (e.g., she/her, he/him, they/them):**

Identities you'd like to share (e.g., race, gender, ability status, sexual orientation, etc.):

Email: **Phone:**

Address:

Financially responsible party (if not self): **Legal Guardian(s), if under 18:**

Name: **Name:** **Name:**

Email: **Email:** **Email:**

Phone: **Phone:** **Phone:**

Are legal guardians in agreement in contacting us? Y N

How did you learn about the Gaudiani Clinic?

Medical History

1. **What is your primary reason for seeking outpatient treatment at the Gaudiani Clinic?**

2. **Would you say you are currently struggling with an eating disorder or disordered eating?** Y N

   If so, would you please describe the behaviors you are currently engaging in? (e.g., dieting, restricting, bingeing, purging, exercise, medication abuse, etc.)

3. **Please list any current physical/medical concerns that you have as well as notable medical and mental health diagnoses.**

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4. **Have you ever had a bone density test?** Y N Never been tested

   If so, when (month/year)?
   What were the results (i.e., normal/osteopenia/osteoporosis)?
   Have you had any broken bones (including stress fractures)?

   For patients assigned female at birth:
   Are you currently menstruating regularly? Y N
   Have you lost your period for more than 3 months in a row in the last 3 years? Y N
   Are you currently on any form of hormones (including an IUD)? Y N
   Please list: _____

5. **Please list your medications in as much detail as possible. Only include ones you're actually taking. Include name of the medicine, dose, frequency. Please also include supplements/vitamins you take regularly and feel free to create additional rows if needed.**

Name of medicine/supplement	Dose	Frequency

   <u>Please list any allergies:</u>

6. **How many alcoholic drinks do you consume in a week?**

7. **Do you use any other substances not prescribed for you (e.g., marijuana, cocaine, opiates, etc.)? Which one(s) and how often?**

8. **Do you currently use, or have you used any nicotine products in the past? Which one(s) and how often?**

9. **Please let us know about any particularly positive or negative experiences you've had with medical providers in the past if you wish to share them.**

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10. **Have you received treatment for an eating disorder?** Y N
    If so, please list where, approximately when, and what level of care:

11. **Please let us know any family history of medical or psychological issues. Include, if applicable, parents, siblings, and anyone in the more extended family who has/had an eating disorder.**

12. **Have you attempted suicide in the last three years?** Y N
    If yes, please explain, including current safety plan, if applicable:

13. **Do you need referrals to a multidisciplinary team [such as a dietitian, therapist, psychiatrist, or medical specialist (e.g., OBGYN)]?**

14. **What are some medical and nursing-related goals you have for your outpatient treatment? This can include things such as: improved communication between my doctor and my outpatient team, improved access to my doctor when I have a concern, warmer and more personal relationships with my doctor and nurse, focused medical workups, faster access to needed treatment, etc.**

15. Please list any current providers (we will reach out to these providers only with your consent to do so):

Name:	**Provider type:**
Name:	**Provider type:**
Name:	**Provider type:**
Name:	**Provider type:**
Name:	**Provider type:**

RASH-PF Mini Screen

16. **Please take a moment to complete Gaudiani Clinic Mast Cell Activation Syndrome Mini Screen:**

Reactions: Do you feel you have physical reactions to food, medications, scents or body products? Y N

Alcohol: When you drink alcohol or use alcohol-based products like hand sanitizer, do you get flushed, itchy, have abdominal pain/distress, worsened mood, joint pains, or feel "flu-ish"? Y N

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Skin: Do you often get rashes, hives, or itchy skin? Y N

Heat: Do you feel unwell, swollen, rashy/itchy, or fatigued after spending time in the heat or sun? Y N

Pain: Do you experience pain regularly, especially joint, digestive, head or muscle pain? Y N

Fatigue: Do you feel chronically or frequently unexpectedly fatigued? Y N

Insurance and Pharmacy

Contact/disclose information to insurance company? Y N

Are you currently enrolled in: Medicare? Y N **Medicaid?** Y N **Kaiser?** Y N

The Gaudiani Clinic is not an approved provider for Medicare or Kaiser (i.e., services rendered are not eligible for reimbursement and our physicians are unable to write medical orders; if you have an in-network provider willing to partner with us on your care, please let us know). The Gaudiani Clinic is not able to see patients who have an active Medicaid Plan.

Insurance company Name:

Policyholder name: **DOB:**

Group number: **ID number:**

Plan name: **Phone number on back of insurance card:**

Rx: **RxBin:**

Preferred pharmacy (name & phone number):

****Please email us a copy of your commercial insurance card, photo ID, and pharmacy card (front/back).**

As the person completing this form, I agree that the information offered is true and correct to the best of my knowledge:

Name of Person completing this form: _____

Date: _____

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Please include some additional information for Aaron's Gift for their consideration with their review of your application package.

1. What are some medical and nursing-related goals you have for your care at the Gaudiani Clinic?

2. Tell us a little bit about your life and your hopes for the future.

3. How will financial assistance from Aaron's Gift help you?

4. What are/have been your barriers to treatment and/or recovery?

X _____ _____

Patient Signature **Date**

X _____ _____

Legal Guardian Signature (where applicable) **Date**

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Authorization for Release of Information

I, _____ (patient or legal guardian), hereby authorize the Gaudiani Clinic to ***exchange*** information with the following:

Provider/person name: Aaron's Gift

Relationship to patient: Scholarship Organization Address: California

Phone: _____N/A_____Fax: _____N/A_____ Email: giftfromaaron@gmail.com

Type of Information to be exchanged (**select one**):

X **Complete Record** (including records relating to mental healthcare including notes, communicable diseases / HIV & AIDS, and alcohol and drug abuse)

☐ Complete Record *with the exception of (select all to be **excluded**)* __ mental health records __ communicable diseases / HIV & AIDS __ alcohol and drug abuse

☐ **Other:** _____

The purpose of this disclosure is to facilitate any treatment or consultation, billing or payment, and other uses as I may define: _____. The designated information can be transmitted by fax, electronic mail or other electronic file transfer mechanisms. Additionally, the content of the released information may be discussed by telephone. This consent is in effect for one (1) year after the date that care/membership with the Gaudiani Clinic has concluded. I understand that I may revoke this authorization, in writing, at any time unless action based on it has already take place. I understand that treatment or payment cannot be conditioned on the signing of this authorization. I further understand that the potential exists for re-disclosure of my records in which case it may no longer be protected under the HIPAA privacy regulations.

This is to certify that I have given consent freely and voluntarily and that I have been offered a copy of this signed authorization.

_____ _____

Patient Name (printed) Date of Birth

_____ _____

Patient/Legal Representative Signature Date

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Authorization for Release of Information

I, _____ (patient or legal guardian), hereby authorize the Gaudiani Clinic to ***exchange*** information with the following:

Provider/person name: _____

Relationship to patient: _____ Address: _____

Phone: _____Fax: _____ Email: _____

Type of Information to be exchanged (**select one**):

☐ **Complete Record** (including records relating to mental healthcare including notes, communicable diseases / HIV & AIDS, and alcohol and drug abuse)

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Provider/person name: _____

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Type of Information to be exchanged (**select one**):

☐ **Complete Record** (including records relating to mental healthcare including notes, communicable diseases / HIV & AIDS, and alcohol and drug abuse)

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☐ **Other:** _____

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_____ _____

Patient Name (printed) Date of Birth

_____ _____

Patient/Legal Representative Signature Date

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AARON'S GIFT

Financially responsible party name: _____

Patient name: _____

Address: _____

Home phone: _____Cell phone: _____

E-mail: _____

Income

Annual income of financially responsible party	$
Spouse/partner annual income	$
Annual untaxed income (child support, SSI, other)	$
Estimated assets (e.g., savings)	$
ANY other income available to patient (including assistance from other sources)	$
TOTAL income available to patient	$

Expenditures
(list of notable monthly output)

E.g., Mortgage, tuition, therapist, RD, etc.	$
	$
	$
	$
	$
	$
	$
	$
	$

Please explain any special circumstances you would like to have considered in this application. (Add additional pages if needed)

_____

_____

_____

_____

I, the undersigned, understand and agree that all of the information provided above is true and correct. If any of this information is found to be false, care provided by the clinic will be terminated and any upcoming appointments will be cancelled. Additionally, all cancellation fees for scheduled appointments may still be collected and refunds may not be issued as per the policies of the clinic providing care.

_____ _____

Patient Name (Printed) Financially Responsible Party Name (Printed)

X _____ _____

Financially Responsible Party Signature Date

Attachments: ☐ W2 *OR* most recent annual tax return ☐ Last 3 paystubs

Attach Most Recent W2

Attach Most Recent **3** Paystubs

Attach Provider Referral Letter

(Alternatively, have the provider send directly to the clinic at info@gaudianiclinic.com)

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Scholarship Duration Reminder Form & Consent

The Gaudiani Clinic is honored to partner with Aaron's Gift to increase access to specialized medical support through needs-based scholarships. **Please note that if/when a scholarship is granted, it lasts for up to one (1) year only. We are not able to offer extensions for any reason** including really good reasons (e.g., we really care about you and would love to keep seeing you and/or you might continue to need specialized medical support and/or comparable care may not readily exist, etc.). We begin talking about a transition to another physician around six months into the 12-month membership.

Please take a moment to check in with yourself as you imagine this timeline for care, as it may not be a fit for all.

☐ I understand this scholarship lasts for up to one (1) year only.
☐ I understand I will not be offered a scholarship extension.
☐ I fully consent to proceed with offered care.

_____ _____

Patient Name (Printed) Financially Responsible Party Name (Printed)

_____ _____

Patient, Legal Guardian, or Authorized Representative Signature Date

_____ _____

Financially Responsible Party Signature (if not patient) Date