Endometriosis Foundation of Houston

Treatment Scholarship Program

REQUIREMENTS

Please submit the following REQUIRED documents along with this completed application via email to healinghou@gmail.com by June 15, 2025.

REQUIRED - **Personal Story (250–500 words):** We want to hear about your journey with endometriosis. Tell us where you are now in your endo journey and share a little about who you are. We encourage you to explain why you feel you would be a worthy candidate for the Healing Hou Scholarship. How would this opportunity impact your life and your care? Help us understand your story, your needs, and your goals.

REQUIRED - Copy of most recent household tax return **OR** copy of the last two (2) pay stubs. **PLEASE BLACK OUT/REDACT YOUR SOCIAL SECURITY NUMBER.**

REQUIRED – Copy of government issued identification. Applicants must be at least 18 years of age. We are not able to consider minors at this time.

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 **June 15, 2025**. 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 **"2025 Healing Hou Application."** We will only accept applications submitted via email.

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

Appointments: Recipients MUST initiate contact with their clinician by July 15, 2025 and complete all appointments by December 31, 2025.

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

Endometriosis Foundation of Houston

Treatment Scholarship Program

2025 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: _____

I am applying for:

☐ Pelvic Floor Physical Therapy

☐ Mental Health Therapy

☐ Both, but my 1st choice is _____

2. ENDOMETRIOSIS

How did you hear about EFHOU? _____

_____

Have you been diagnosed with or suspect you have endometriosis? Please explain:

_____

_____

_____

Tell us about your symptoms.

_____

_____

_____

Do you have any other/comorbid health conditions? Please explain:

_____

_____

_____

What have you tried in order to manage endometriosis symptoms?

_____

_____

_____

Who, if any, is the physician managing your endometriosis care?

_____

Do you have a surgery planned/scheduled for 2025? If so, when and with who?

_____

_____

3. **HEALTH INSURANCE**

Do you have health insurance? ☐ NO ☐ YES

If yes, list your insurance provider: _____

Please answer if applying for the Pelvic Floor PT Scholarship

Do they pay for outpatient physical therapy services? ☐ YES ☐ NO

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

Copay/coinsurance amount? _____

Please answer if applying for the Mental Health Scholarship

Do they pay for outpatient mental health services ("therapy")? ☐ 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**

We require a copy of the first page of your most recent federal tax return OR 2 recent pay stubs. All financial information provided will remain confidential. Financial need will play a role in determining scholarship recipients but is not the sole determinant.

NOTE: Please black out/redact your social security number on any documents you submit.

Select one:

☐ Employed ☐ Unemployed Since _____ ☐ Retired Since _____

☐ Disabled Since _____ ☐ Active Military Since _____

Applicant Annual Income: _____

Annual Household Income (if different): _____

Total number of persons in household: _____

Total number of wage earners in household: _____

Total number of dependents in household: _____

Please estimate the amount of your total monthly expenses: _____

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</u>

(You may skip this section if you are ONLY applying to the mental health option)

A referral is required for physical therapy. 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 or WERE** 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 awarded this scholarship?

_____

_____

_____

Pelvic floor PT may be triggering for some people. Do you feel ready to do this work?

_____

_____

Dr. Karen Kowenski (Bellaire) and Dr. Leslie Guier (The Woodlands) treat patients on Monday, Tuesday, and Thursday from 9:30 to 2:30. Please list all of your availability during these times.

_____

_____

Do you have a location or PT preference?

☐ Karen/Bellaire ☐ Leslie/The Woodlands

☐ I am willing to see Karen or Leslie but I prefer _____

Do you have reliable transportation to appointments? ☐ YES ☐ NO

6. <u>MENTAL HEALTH THERAPY</u>

(You may skip this section if you are ONLY applying to the physical therapy option)

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 through Thursday 10 am - 1 pm and Monday and Thursday evenings. Please list all of your availability during these times.

_____

_____

Agreement

I understand that I may be asked to participate in an interview via Zoom in June 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 my endometriosis care, but further treatment may be needed beyond the scholarship's scope.

☐ YES ☐ NO

I am confirming that I live in Texas 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

Treatment 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 to and from appointments. No special accommodations will be made. Physical therapy sessions will be held in Bellaire OR The Woodlands. Mental health appointments will be virtual and require internet access.
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 **July 1**. Scholarship recipients are required to schedule an appointment **by July 15**, 2025 and finish treatment by **December 31, 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

Treatment 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 providing 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)

Please email the complete application to us at **healinghou@gmail.com** with the subject line **2025 HEALING HOU APPLICATION.**

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 and Informed Consent
3. Personal story
4. Copy of driver's license or government issued identification card.

Deadline: June 15, 2025