Application For Safta Fund
Eating Disorders Foundation of Canada

Date: _____

Patient Information:

Name:		**DOB:**
Phone #	**Email Address:**	
Current Address:		

Dr. Information:

Name:	**Email:**	**Phone #**
Family Physician:		
Specialist:		

Who is Recommending you to apply for this fund?: _____

Phone # & Email Address: _____

Current Treatment Facility: _____

Address: _____ **Phone #:** _____

Diagnosis: _____

_____

History of: ☐**Food Restriction** ☐**Purging** ☐**Binge Eating**

Height: _____ **Weight** _____ **Blood Pressure** _____

BMI Current: _____ **3 Months Ago:** _____ **1 Year Ago:** _____

Substance Abuse, Please List Current Use: _____

Past Use: _____

Last Hospitalization: _____ **Total # of Hospitalizations:** _____

Legal State current: _____ **History** _____

Financial Status: ☐**ODSP** ☐**Independent** ☐**Other** _____

Living Arrangements: ☐**Group Home** ☐**Family** ☐**Apt** ☐**Other** _____

Current Support: ☐**Individual** ☐**Group** ☐**CMHA** ☐**Crisis** ☐**Other** _____

Please list and or attach all psychiatric and medical prescriptions: _____

_____

Who will be responsible for your follow up care and for what length of time?

_____

Address of Potential Apartment & Monthly Rental Cost: _____

_____

Please attach a letter describing your current situation and why you believe you qualify for the Safta Fund.

Please also attach a copy of your release of information documentation.

Please call or email the Eating Disorders Foundation of Canada prior to the application process. Funding is dependent upon donations and may be limited.

Eating Disorders Foundation of Canada
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