(for office use only) _____-_____

Scholarship Application

Family Hope Foundation
7086 8th Avenue
Jenison, MI 49428
(616) 780-3839
www.familyhopefoundation.org

Please read the Scholarship Guidelines thoroughly before completing this application.
Every question must be answered for application to be complete.

Applications are due by 5:00pm on April 1 or October 1.
You must submit three total stapled copies of this completed application.

Applicant Information: read the guidelines before completing this page

1. Applicant's Name: _____ _____
Last First

2. Birthdate: _____/_____/_____ **3.** Age: _____ **4.** M / F

5. Has applicant applied for a Family Hope Foundation scholarship in the past? ( )Yes ( )No

5a. If "Yes" to 5: Has applicant received a Family Hope Foundation scholarship in the past? ( )Yes ( )No

6. Are you willing to be the recipient of a *Gift of Hope* Scholarship (see guidelines)? ( )Yes ( )No

7. Check the **one disability category** that most accurately represents the applicant **(do not check more than one)**:

( ) Autism Spectrum Disorder or Pervasive Developmental Disorder
( ) Developmentally Delayed
( ) Emotionally/Psychologically Impaired
( ) Specific Learning Disability
( ) Physically Impaired
( ) Sensory Processing Disorder (only)
( ) Severely Multiply Impaired
( ) Speech and Language Disability

8. Applicant's Primary Diagnosis/Disability: _____

8a. Applicant's Secondary Diagnoses/Disabilities (list all): _____

_____

9. Briefly tell us about the applicant and why you feel he/she would be a good candidate for this scholarship:

_____

_____

_____

_____

_____

_____

Applicant Name: _____ (for office use only) _____-_____

Family Information: read the guidelines before completing this page

10. Parties responsible for applicant: ( ) Parent(s) ( ) Guardian(s) ( ) Self

_____ _____
Last First

_____ _____
Last First

11. Address:

_____
Street City St Zip

12. County (not country): _____ **13.** Email _____

14. Phone: (_____)_____ (_____)_____
Home Cell

15. Number of dependent family members in home: children _____ adults _____

16. How did you hear about Family Hope Foundation? _____

Financial Information: This is an application for financial assistance; you must prove financial need.

17. Amount of scholarship being requested: $ _____ (not to exceed $1,000)

18. What is the cost of therapy being requested? $_____ (per: hour/week/month)

19. Check the applicant's medical coverage (check all that apply):
( )Private Insurance ( )Medicaid/MI Child ( )Children's Special Health Care ( )None

20. Will insurance cover any of the cost associated with this therapy? (Check your latest policy before answering!)
( )Yes ( )No ( )Applicant does not have any insurance coverage, as noted above.

20a. If "Yes" to 19, explain your coverage: _____

_____

21. Check which best describes your financial situation:
( ) Two-parent, two-income (part or full-time) ( ) Single parent, single-income
( ) Two-parent, single-income ( ) Single parent, no income
( ) Two-parent, no income ( ) Other _____

22. Do you have multiple family members with special needs? ( )Yes, explain in number 22 below ( )No

23. Explain ANY of the circumstances that contribute to your FINANCIAL need for a scholarship, including items checked in the section above (attach an additional page, if needed):

_____

_____

_____

_____

_____

Applicant Name: _____ (for office use only) _____-_____

Therapy Information: read the guidelines before completing this page

24. Name the type(s) of therapy being requested for this scholarship: _____

25. List the information for the provider you choose to receive therapy from for this scholarship (*see guidelines):

Name of therapy provider: _____
Do you have an evaluation from the provider: ( )Yes ( )No
Has your child received therapy from this provider: ( )Yes ( )No ( )Currently
Therapy Provider Address:

_____
Street City St Zip

Phone: (_____)_____

26. List **all** therapies, <u>including the above</u>, that the applicant receives at **school (S)**, receives **privately (P)** or are **desired (D)** for the applicant and check the appropriate choice.

_____ ( )S ( )P ( )D _____ ( )S ( )P ( )D

_____ ( )S ( )P ( )D _____ ( )S ( )P ( )D

27. Is therapy being requested by a physician? ( )Yes ( )No **27a. If Yes, please complete:**

Physician: _____ Practice: _____

Address:

_____
Street City St Zip

28. Please explain in detail why this therapy will be beneficial to the applicant:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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