(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 March 1 or September 1.
You must submit three total stapled copies of this completed application.

Applicant Information:

1. Applicant's Name: _____ _____
Last First

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

5. Applicant's Primary Diagnosis: _____

6. Applicant's Formal Secondary Diagnoses/Disabilities **(list all)**: _____

_____

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
( ) Physically Impaired
( ) Sensory Processing Disorder (only)
( ) Severely Multiply Impaired
( ) Specific Learning Disability
( ) Speech and Language Disability

8. Briefly tell us about **who** the applicant is as a person (attach an additional page, if needed):

_____

_____

_____

_____

General Information:

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

9a. If "Yes" to 9: Has applicant received a Family Hope Foundation scholarship in the past? ( )Yes ( )No

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

11. Therapy Provider (see guidelines): _____

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

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

Family Information:

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

_____ _____
Last First

_____ _____
Last First

14. Address:

_____
Street City State Zip

15. County (not country): _____ **16.** Email _____

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

18. Number of family members in home: Children _____ Adults _____

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

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

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

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

22. 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.

22a. If "Yes" to 22, explain your coverage (see guidelines): _____

_____

23. 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 _____

24. Do you have multiple family members with special needs? ( )Yes, explain in number 25 below ( )No

25. 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:

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

_____

27. Therapy Provider (see guidelines): _____

Therapy Provider Address:

_____

Street City State Zip

Therapy Provider Phone: (_____)_____

28. Has the applicant been evaluated by this provider: ( )Yes ( )No

29. Has the applicant received therapy from this provider: ( )Yes, currently ( )Yes, in the past ( )No

30. 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

31. Is therapy being requested by a physician? ( )Yes ( )No

31a. If "Yes" to 31, please complete:

Physician: _____ Practice: _____

Address:

_____

Street City St Zip

32. Please explain in detail why this therapy will be beneficial to the applicant (attach additional page, if needed):

_____

_____

_____

_____

_____

_____

_____

_____

_____