(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 the application to be complete.
- Applications **ONLY** accepted February 1 - March 1 OR August 1 - September 1.
- You must submit **three** total stapled copies of this completed application.

Applicant Information:

1. Applicant's Name: _____ _____
Last First

Any previous names (if applicable):_____

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
( ) 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 accept funds from our Designated Scholarship Program (see guidelines)? ( )Yes ( )No

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

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

Family Information:

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

_____ _____
Last First

_____ _____
Last First

13. Address:

_____
Street City State Zip

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

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

17. Number of people residing in the home: Children _____ Adults _____

18. Do you have multiple family members with special needs who also require therapy? ( ) Yes ( ) No

18a. If "Yes" to 18, will another family member also be applying for a scholarship? ( ) Yes ( ) No

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

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 portion of the costs 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:
( ) Deductible (enter amount) _____
( ) Out of Pocket maximum (enter amount) _____
( ) Copay ONLY per visit (enter amount) _____

23. What is your total/combined Household Annual Income?
( ) $0 - $24,999
( ) $25,000 - $49,999
( ) $50,000 - $74,999
( ) $75,000 - $99,999
( ) $100,000 - 149,999
( ) $150,000 and above

24. Other than lack of insurance coverage, explain any other circumstances that contribute to your FINANCIAL need for a scholarship. (attach an additional page, if needed):

_____

_____

_____

_____

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

Therapy Information:

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

_____

26. Therapy Provider **(list according to guidelines**): _____

Therapy Provider Address:

_____

Street City State Zip

Phone: (_____)_____

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

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

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

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

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

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

_____

_____

_____

_____

_____

_____

Application was completed by: _____

Relationship to the applicant: _____

( ) I have read and agree to follow all Scholarship Guidelines (found on Family Hope Foundation website)

Application Verification: If applicant is selected to receive a scholarship, I commit to complying with all follow up requirements and paperwork submissions within one month of being notified. I understand that failure to submit paperwork within the one-month deadline could result in forfeiture of the scholarship.

_____

Signed Date