SCHOLARSHIP APPLICATION

HEALTH CARE SCHOLARSHIP PROGRAM

HOW TO APPLY

This application must be submitted no later than **June 15th** *with the information requested below.* ***Applications will not be reviewed by the committee unless all of the required information has been received.*** *Please answer each question as it is presented on the application. If a question does not apply to you, mark your answer with n/a.*

All applicants must submit the following:

1. A completed and signed Scholarship Application.

2. A copy of a Letter of Acceptance from an approved accredited program indicating you have been accepted into a program leading to an approved health care program.

3. An official high school transcript showing all grades, including SAT & ACT scores, regents grades, your class rank and cumulative average.

4. On a separate sheet of paper, write a personal statement of no more than one page detailing your career aspirations, personal goals, leadership roles, activities or honors in high school and the community, your financial need and other comments relevant to your application.

5. Please submit a letter of recommendation from a non-relative faculty member or a non-relative supervisor. The letter of recommendation must be submitted with your application.

6. Page 1 & 2 of your most recent tax return (IRS Form 1040). If you are a dependent of your parents, please submit page 1 and 2 of their most recent tax return (IRS Form 1040).

Submit this application to:
Scholarship Committee
Adirondack Health Foundation
P.O. Box 120
Saranac Lake, NY 12983

ELIGIBILITY

- The Adirondack Health Foundation Scholarship Selection Committee determines each award individually based on the required information provided by the applicant.
- Applicants must provide proof they have been accepted into a course of study leading to a degree in an approved healthcare career.
- Applicants must be full time students taking a minimum of 12 credit hours per semester.
- Applicants must live within the primary service area of Adirondack Health.
- Recipients must be in good standing and maintain a grade point average of 3.0 or higher while enrolled in order to be considered for a second year scholarship and not be subject to repayment of scholarship amounts previously awarded.
- At the time of application, applicants must agree to work for Adirondack Health for one (1) year after graduation, if a position is available (as determined by Adirondack Health).

(scroll below)

PERSONAL PROFILE

Please Print or Type:

Name _____
(First) (M.I.) (Last)

Home Address: _____
(Street Address including number)

City/Town _____ State _____ Zip _____

Mailing Address (if different) _____

Telephone (____) _____ Email address: _____

Age _____ Date of Birth _____/ _____/ _____ Social Security # _____

Do you reside with your parents or spouse? Yes ____ No ____

Name of Parents/Spouse _____

Occupation of Parents/Spouse _____

List Other Family Dependents Along with Ages _____

Total adjusted gross income for the last calendar year according to IRS form 1040:

Parents'/ Household's Gross Income: _____ Year: _____

Did you have income in the previous year? Yes ____ No ____ If so, how much employment income did you earn? $_____ Where were you employed? _____

Present employment: _____ Full time ____ Part time ____

Do you have an immediate family member* who is currently, or has ever been, employed by Adirondack Health or the Adirondack Health Foundation? Yes ____ No ____

If yes, please provide the person's name, title and relationship to you:

* *"Immediate family member" means your (1) husband or wife, (2) birth or adoptive parent, child or sibling, (3) stepparent, stepchild, stepbrother or stepsister, (4) father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister- in-law, (5) grandparent or grandchild, or (6) spouse of a grandparent or grandchild.*

Do you have an immediate family member* who is currently, or ever was, on the medical staff of Adirondack Health? Yes ____ No ____

If yes, please provide the person's name, title and relationship to you:

* *"Immediate family member" means your (1) husband or wife, (2) birth or adoptive parent, child or sibling, (3) stepparent, stepchild, stepbrother or stepsister, (4) father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister- in-law, (5) grandparent or grandchild, or (6) spouse of a grandparent or grandchild.*

Which accredited college will you be attending? _____

What course of study do you intend to follow? _____

Are you a U.S. Citizen? _____ If no, please explain: _____

Have you ever been convicted of committing a felony offense involving marijuana, controlled substances or dangerous drugs or an assault, physical injury or death? No ____ Yes ____

If yes, please explain: _____

Are you in default or do you owe a refund on any educational loan? No ____ Yes ____

If yes, please explain: _____

RECOMMENDATIONS

Please submit a letter of recommendation from a non-relative **-for high school students** - faculty member; **for non-traditional students** - work supervisor.

ACADEMIC PROFILE

Name of High School Attended: _____

Address: _____

For High School Students:

Expected Date of Graduation: _____ Please attach a copy of your high school transcript showing SAT & ACT scores, grades, your class rank and cumulative average.

For Non-Traditional Students:

Year of High School Graduation: _____

Other institutions previously attended and credits earned (if any):

Date of Entrance: _____

In what educational program were you enrolled?

Associates ____ Bachelors ____ Masters ____ In what major? _____

Please attach a transcript of your grades.

FINANCIAL INFORMATION

Please note: Each line of the financial information section of the application must be completed. If you are not receiving aid or income in the categories listed below, please mark that line with "n/a" as not applicable.

Academic Program Costs and Support

What is the estimated annual cost at the college you expect to attend?

Tuition:	$_____	Books:	$_____
Room:	$_____	Incidentals:	$_____
Board:	$_____	**TOTAL COSTS:**	$ $0.00

Please indicate the level of support you will be or are currently receiving from the programs listed below on an annual basis. Indicate the amount for each (estimate aid if you don't have exact figures).

Pell Grant	$_____	Voc Rehab	$_____
Scholarship	$_____	V.A. Benefits	$_____
Work Study	$_____	Other	$_____
Student Loans	$_____	**TOTAL SUPPORT:**	$ $0.00

Income

Please indicate the annual income you anticipate upon college entrance from the sources listed below. Indicate the amount for each.

Parental Support	$_____	Unemployment	$_____
Employment	$_____	Social Security	$_____
Child Support	$_____	Worker's Comp	$_____
Alimony	$_____	Other	$_____
Social Services	$_____	**TOTAL INCOME:**	$ $0.00

Verify your adjusted gross income:

You must include a copy of Page 1 & 2 of your recent tax return - IRS Form 1040.
If you are a dependent of your parents,
you must include page 1 & 2 of your parents most recent IRS 1040.

AGREEMENT

I certify that the information I have provided in this application is true and accurate. I will notify the Foundation if any of this information changes.

I understand and agree that the purpose of the Scholarship Program is to defray the cost of tuition and any scholarship awards will be made payable each academic year to the college I am attending, so long as I have met all of the Scholarship Program requirements.

I understand and agree that I am obligated to repay the full amount of any scholarship awarded, if I change my course of study to something other than an approved healthcare program or fail to meet the requirements of the Scholarship Program, as described in the Health Care Scholarship Program Agreement.

I understand and agree that the scholarships offered by the Adirondack Health Foundation are dependent upon the availability of Foundation funding and cannot be guaranteed.

I understand and agree that I am obligated to notify the Foundation if my student status changes from that which is indicated in this application.

I hereby give permission to use any general, non-financial information included with this application for publicity purposes; to provide the Foundation with photographs of myself and give permission for the usage of such photographs; and to participate in scholarship recognition ceremonies of the Foundation's choosing.

I hereby authorize the release of this application and any relevant supporting information to person involved in the selection process and awarding of scholarship recipients.

Applicant's Signature: _____ **Date:** _____

Scroll below:

ADIRONDACK HEALTH FOUNDATION

HEALTH CARE SCHOLARSHIP PROGRAM AGREEMENT AND PROMISSORY NOTE

I, _____, by applying for the Health Care Scholarship Program offered by the Adirondack Health Foundation, do hereby agree as follows.

Scholarship Recipient Responsibilities

If I am awarded a Health Care Scholarship, I agree that I shall:

- Maintain satisfactory progress in a course of study leading to a degree in an approved healthcare field of study. Satisfactory progress means being in good standing and maintaining a grade point average of 3.0 or higher each year.
- Submit a grade report for each year along with a course schedule for the upcoming year immediately after the completion of the first year. I understand that further scholarship funds may not be awarded if I have not maintained satisfactory progress in my course of study.
- Keep the Adirondack Health Foundation apprised of any change in my academic status while receiving scholarship assistance.
- During my final semester, verify with the Foundation that I have consulted with the Adirondack Health Human Resources Office regarding possibilities for employment. *Such consultation in no way assures employment by Adirondack Health.*
- Upon sixty (60) days of graduation, will work at Adirondack Health for a period of one (1) year in a position that requires the degree awarded during my course of study, assuming a position is available as determined by Adirondack Health in its sole discretion.

Repayment Requirements

1. I understand and agree that I shall be required to repay any scholarship amounts awarded if the following occurs:
    - I fail to maintain satisfactory progress, as defined above, in a course of study leading to a degree in an approved healthcare program for each year I am enrolled in the program.
    - I fail to accept employment at Adirondack Health if a position is offered within sixty (60) days of graduation.

2. If employment is not available at Adirondack Medical Center within my field of study within sixty (60) days of graduation, I understand I am not obligated to repay any scholarship funds awarded.

Miscellaneous

1. I understand and agree that the scholarships offered by the Adirondack Health Foundation are dependent upon the availability of Foundation funding and cannot be guaranteed.
2. I understand and agree that such scholarships may be considered taxable by the Internal Revenue Service and that I am responsible for any tax liability incurred as a result of this award. The Adirondack Health Foundation will provide no tax information to me or to the Internal Revenue Service.

I hereby consent and agree to the foregoing.

Student Signature _____ **Date** _____

For Office Use Only

Application received was complete. _____ Date: _____

Date application approved: _____ Award amount $ _____

Signature _____ Date: _____
Foundation Executive Director