



# Scholarship Application

Family Hope Foundation  
7086 8<sup>th</sup> Avenue  
Jenison, MI 49428  
(616) 780-3839

www.thefamilyhopefoundation.org

**Please read the Scholarship Guidelines thoroughly before completing this application.  
Only completed applications, following the guidelines, will be considered for funding.  
Applications are due by April 1 and October 1.**

Applicant's Name: \_\_\_\_\_  
Last First

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ M / F County: \_\_\_\_\_

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

**If Yes:** Spring or Fall of what year/s? \_\_\_\_\_ Amount received? \_\_\_\_\_

Applicant's Primary Diagnosis/Disability: \_\_\_\_\_

Applicant's Secondary Diagnoses/Disabilities: \_\_\_\_\_

( ) Parent(s) \_\_\_\_\_  
( ) Guardian(s) Last First  
( ) Self Last First

Address: \_\_\_\_\_  
Street City St Zip

Phone: \_\_\_\_\_  
Home Alternate Email

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

### Therapy Provider Information (List the provider you choose to receive therapy from for this scholarship):

Name the type of therapy being requested for this scholarship: \_\_\_\_\_

Name of therapy provider: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City St Zip

Phone: \_\_\_\_\_

**List all therapies**, including the above, 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

Amount of scholarship being requested: \$ \_\_\_\_\_ (not to exceed \$1,000)

What is the anticipated total cost of therapy being requested? \$ \_\_\_\_\_ (per hour, month, year?)

If known, what is the anticipated duration of time needed for therapy? \_\_\_\_\_

Will the need for therapy be complete after this scholarship money is used? Yes / No

Is therapy being requested by a physician? Yes / No

**If Yes:** Physician: \_\_\_\_\_ Practice: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City St Zip

Have you made previous attempts to find other financial assistance? Yes / No

**If Yes, list:** to whom, when and the amount received/outcome of request. \_\_\_\_\_

Will insurance cover any of the cost associated with therapy? Yes / No **If Yes, how much will it cover?** Please list your deductible and percentage of coverage after deductible. \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Number of family members in home: children \_\_\_\_\_ adults \_\_\_\_\_

Please check and explain all financial circumstances that affect your need for financial assistance; list any others:

- ( ) Single parent
- ( ) Multiple children with special needs
- ( ) Two-parent, single-income
- ( ) Unemployed

\_\_\_\_\_  
\_\_\_\_\_

How did you hear about Family Hope Foundation? \_\_\_\_\_

**Optional:** The following information will be used only for statistical purposes to aid Family Hope Foundation in receiving funds from outside sources. The scholarship review committee will not see this section and it will not weigh in the decision to fund your application.

- Applicant's race: ( ) Caucasian, non-Hispanic ( ) Native American, Native Alaskan
- ( ) African American ( ) Asian
- ( ) Hispanic ( ) Other: \_\_\_\_\_

- Family's (or child's, if different) socio-economic status:
- ( ) under \$25,000 ( ) 50,000-\$75,000
- ( ) 25,000-\$40,000 ( ) 75,000-\$100,000
- ( ) 40,000-\$50,000 ( ) 100,000 and above