Dear Community Health Foundation Applicant:

Enclosed is the Community Health Foundation Scholarship packet for, returning applicants. Contents include the following:

* Foundation Fact Sheet
* Scholarship Guidelines
* Scholarship Application
* Course Schedule must be attached

All completed applications are to be submitted by 4:00 p.m. on February 1st  or September 1st, to the following address:

Community Health Foundation

c/o Kristina Soerries

1500 State Street

Lexington, MO 64067

chflafayette@gmail.com

If you have any questions, please call 816.785.9087.

Thank you for your interest in this scholarship.

Community Health Foundation

Scholarship Committee

**Our Mission**

The Community Health Foundation of Lafayette County is dedicated to enhancing healthcare services in and around Lafayette County by providing scholarships to individuals who are seeking health and medical education and funding the healthcare infrastructure.

**Our Vision**

Through our scholarship initiative, The Community Health Foundation desires to increase the availability of medical and healthcare professionals within our communities. Individuals are eligible to apply for scholarships to aid and assist in funding his/ her pursuit of a degree in the healthcare or medical fields. In addition, The Community Health Foundation will consider the funding of projects to support our area’s healthcare needs through healthcare awareness initiatives.

Today, a volunteer board of community members governs the Foundation, guiding its development and providing direction for fundraising efforts and for the distribution of those funds. The 2023 Community Health Foundation Board is listed below:

|  |  |  |
| --- | --- | --- |
| **Board Member** | **City** | **Title** |
| Darrel Box | Lexington | President |
| Chad Thompson | Lexington | Vice- President |
| Teri James | Lexington | Treasurer |
| Kristina Soerries | Higginsville | Secretary |
| Carolyn Boland | Waverly | Director |
| Syble Cretzmeyer | Higginsville | Director |
| Cynthia Riker | Lexington | Director |
| Kelly Geringer | Wellington | Director |
| Jordon Elefson | Lexington | Director  |
| Devin Graf | Blackburn | Director |
| Jim Worthington | Lexington | Director |
| Jackie Bounds | Lexington | Director |
| Laurie Lichte | Lexington | Director  |

 **SCHOLARSHIP REQUIREMENTS**

* Applications are accepted for an individual enrolled/ accepted into a professional healthcare program (ex. Med School, Nursing program and taking nursing classes, occupational/ physical therapy program, EMT, Paramedic, Pharmacy School, etc.)
* Scholarships are awarded twice a year. Once in the Spring Semester and once in the Fall Semester.
* Applications will be accepted twice a year with the deadlines of applications due on February 1st and September 1st.
* First time applicants will ONLY be accepted and processed with the September 1st award period.
* First time applicants are required to submit names of two (2) references that have agreed to write Reference Letters and submit to CHF either thru mail or email.
* Interviews may be required and, if warranted by Scholarship Committee, will be held during month applications are due or as soon as reasonably possible.
* Applicants will be notified by mail or email of either acceptance or denial of awards.
* Applicants must be enrolled in at least 6 course hours for the submitted application period.
* Precedence is given to those applicants that are currently taking healthcare related courses or currently in a healthcare schooling program.
* There are no limits on the number of applications an applicant may submit.
* Amount and number of scholarships are determined by the sole discretion of the Board of Directors based on financial need, school cost, desire to remain in the Lafayette County area, number of applicants, and money available to the Board.
* Scholarship winners will be notified by mail or email. Money will be paid when at least 6 credit hours have been completed with a 2.5 GPA as validated by official transcript for the awarded period. Scholarship checks will be given to the applicant after grades transcripts are received. Mail official transcripts to: Community Health Foundation, c/o Kristina Soerries, 1500 State Street, Lexington, MO 64067.
* Please feel free to contact Kristina Soerries, Community Health Foundation Secretary with any questions and to request applications at 816.785.9087.
* Please mail or email application, reference letters, and course schedule to Community Health Foundation, c/o Kristina Soerries, 1500 State Street, Lexington, MO 64067. Email: chflafayette@gmail.com

I, the undersigned, acknowledge and affirm that I have read the above requirements and understand the terms and conditions contained herein. I further acknowledge that any failure to follow the above terms and conditions will remove my name from consideration for the current application.

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

**APPLICANT SIGNAURE**  **DATE**

**SCHOLARSHIP APPLICATION**

(PRINT) Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street City State Zip Code

Last four of your SSN: \_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Must include a copy of your school ID, Driver’s License, or Government ID.

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

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Highest level of school completed (Circle appropriate)

High School Community College College/ University

Name of Institution where highest level of school completed and year of completion:

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

Name of School in which you have been accepted and will be attending: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anticipated Degree: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anticipated completion/Graduation date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description of your anticipated education program schedule:

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

Upon graduation, please describe your health career employment goals:

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

In association with Jill Thompson’s family, The Community Health Foundation is awarding a scholarship in her name. Jill was an avid public health facilitator in Lafayette County. As an applicant are you pursuing or interested in pursuing a degree with public health focus?

Yes\_\_\_\_\_\_ No\_\_\_\_\_\_

If yes please explain below:

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

On the following lines, list your current and prior work experience; including periods of service and main job description (attach an additional sheet, if necessary).

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

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

Approximate annual cost of educational program: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all financial sources you rely on to pay tuition, fees, books, supplies, room, and board, etc., while attending the educational institution. Include other scholarships, grants, loans, employer tuition reimbursements, jobs (summer and/ or during school) and the amounts from each. I understand that the Scholarship may request a copy of my most recent federal income tax return for their review.

Source Amount

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

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

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

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

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

**AUTHORIZATION**

The undersigned, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorizes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to release the information regarding my grades and progress towards completing my degree or certification at stated institution directly to Community Health Foundation, c/o Kristina Soerries, 1500 State Street, Lexington, MO 64067.

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

Name Date