**ACAP Scholarship Program Application**

|  |
| --- |
| **PLEASE TYPE OR CLEARLY PRINT YOUR ANSWERS.** |
| 1. | Name (*First, MI, Last)*: |
| 2. | Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_ ZIP:\_\_\_\_\_\_\_\_\_\_\_ |
| 3. | Telephone Number: ( ) | 4. | Email: |
| 5. | Date of Birth (mm/dd/yyyy):  |
| 6.  | Are you an enrollee or family member of an enrollee at CenCal Health? [ ]  I am an enrollee. [ ]  A family member, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, is an enrollee.   Relationship to me: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 7. | **If you are under 18**, please provide the name and address of parent(s) or legal guardian(s):Parent(s) or Guardian(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ ZIP:\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| **EDUCATION** |
| 8. | High school:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Year of Graduation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  I hold a GED instead of a high school diploma. Describe any additional education you may have received below:

|  |  |  |
| --- | --- | --- |
| Name of Institution  | Dates Attended  | Year Graduation and Degree (if applicable) |
|  |  |  |
|  |  |  |
|  |  |  |

 |
| 9. | Please indicate whether you are currently enrolled in, have been accepted to, or have applied to a higher education institution. Include the name of the school.  \_\_\_\_Enrolled Name of higher education institution:­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_Accepted Name of higher education institution:­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_Applied Name of higher education institution:­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Proof of acceptance or current student enrollment from the school is** **required prior to receipt of funds.** For example, applicant will be asked to provide a copy of the letter of acceptance from the higher education institution, a transcript if currently enrolled, or similar documentation.  |
| 10. | What specialty/major are you pursuing, or plan to pursue, in your education? |
| 11. | List and briefly describe any work experience you may have.  |
| *Position* | *Employer* | *Dates of Employment* | *Duties*  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| 12.  | List any academic honors or awards you have received. |
| 13.  | Briefly list community-related activities or hobbies that you have been involved in through your school, church, or other organization.  |
| **ESSAY QUESTIONS** |
| Please answer the following questions. **Each response should be 650 words or less**. Please submit your responses on separate paper (or in a separate document) and attach to this application.1. How have you benefited from the medical care, services and/or supports that have been provided by *CenCal Health*? (This can be from medical care you may have received from your doctor, nurse, or other medical professional and/or any contact or experience you have had with CenCal Health?
2. How will your studies further your career in the health care and/or human/social services fields?
3. Why are you a good candidate to receive this award?
 |

### CONFIDENTIALITY WAIVER, ESSAY RELEASE AND STATEMENT OF ACCURACY

I hereby affirm that all the above stated information provided by me is true and correct to the best of my knowledge.

I hereby give *CenCal Health* permission to release any information provided by me in this application to the Association for Community Affiliated Plans and the ACAP Scholarship Program Selection Committee.

I hereby grant CenCal Health and the Association for Community Affiliated Plans permission to use the essay responses provided by me in this application for all purposes and in perpetuity. I waive the right to inspect or approve versions of the essay responses.

I hereby understand that if chosen as a scholarship winner, according to Association for Community Affiliated Plans Scholarship Program policy, I must provide evidence of enrollment/registration at the education institution of my choice before scholarship funds can be awarded.

I hereby understand that if chosen as a scholarship winner, according to Association for Community Affiliated Plans Scholarship Program policy, I will agree to provide a photo that ACAP can use to identify me as the winner in its announcement and any such publicity materials related to the scholarship.

Signature of scholarship applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### REMINDER

All applications must be received by ***November 11, 2020*** to be considered.