



HEALTH PROFESSIONS
EDUCATION FOUNDATION

Giving Golden Opportunities

Allied Healthcare

Scholarship Application

Made possible through funding from Kaiser Permanente



Spring Postmark Deadline: March 24, 2009

Fall Postmark Deadline: September 11, 2009

*Giving Golden
Opportunities by:*

*Increasing the supply of
allied healthcare professionals
practicing in underserved areas*

*Improving access to healthcare in
rural and urban areas of California*

*Helping students pursue a
career in the health professions*

*Awarding allied health professionals
who are dedicated to practicing in
underserved communities*

Application Instructions



If you want receipt confirmation of your application packet, please submit one self-addressed stamped envelope with your application.

You must be a California resident and a citizen or permanent resident of the U.S. to apply.

The **Allied Healthcare Scholarship Program** is offered to students enrolled or accepted in an allied healthcare education program. Students who attend a community college program are eligible for a scholarship up to **\$4,000**. Students who attend a university program are eligible for a scholarship up to **\$4,500**.

The purpose of the Allied Healthcare Scholarship is to: 1) encourage allied healthcare professionals to practice direct patient care in a medically underserved area (MUA) of California; 2) increase the number of appropriately trained allied healthcare professionals; and 3) encourage underrepresented groups to pursue an allied healthcare profession.

Applications for the Allied Healthcare Scholarship are accepted biannually in March and September. Scholarships funded under this program are intended to pay or repay tuition, required fees, books, supplies, and educational equipment costs related to the applicant's allied healthcare education. All awards are subject to the availability of funding.

Scholarship recipients will be required to sign a written contract with the Foundation outlining the provisions which must be met to fulfill the obligations under this program. Failure to comply with the terms of the contract may result in the awardee's repayment of the funds awarded plus interest.

Although this scholarship is funded by Kaiser Permanente, awardees of this program are not obligated to work for Kaiser Permanente.

SELECTION CRITERIA

Selection for the Allied Healthcare Scholarship is based solely on information contained in the application and supporting documentation. Selection for awards is based on the following criteria:

Financial Need - actual or potential financial difficulty in completing education in the absence of the scholarship.

Career Goals - professional goals for the next five (5) to ten (10) years.

Community Service - documented volunteer service and/or activities, particularly in a MUA.

Community Background - family structure, economic background and community where applicant grew up; for example, rural, inner city/urban, suburban, or MUA.

Academic Performance - prior and current academic performance; potential for future academic success. Priority will be given to students who will complete their allied healthcare program within the next two years. Awards are made on a competitive basis.

SCHOLARSHIP ELIGIBILITY

To be eligible for a scholarship, students must sign a contract with the Office of Statewide Health Planning and Development (OSHPD)/ Health Professions Education Foundation and agree to the following terms:

Be enrolled or accepted in one of the following allied healthcare programs: Diagnostic Medical Sonography, Clinical Laboratory Science, Medical Assistant, Medical Imaging, Medical Laboratory Technology, Nuclear Medicine Technology, Occupational Therapy, Pharmacy, Pharmacy Technician, Physical Therapy, Physical Therapy Assistant, Radiation Therapy Technology, Radiologic Technology, Respiratory Care, Social Work, Speech Therapy, Surgical Technician, and Ultrasound Technician.

Nursing students are not eligible to apply for this program. Please visit the Foundation's website at www.healthprofessions.ca.gov and download the Licensed Vocational Nurse, Associate or Baccalaureate Degree Nursing Scholarship Application for eligibility information.

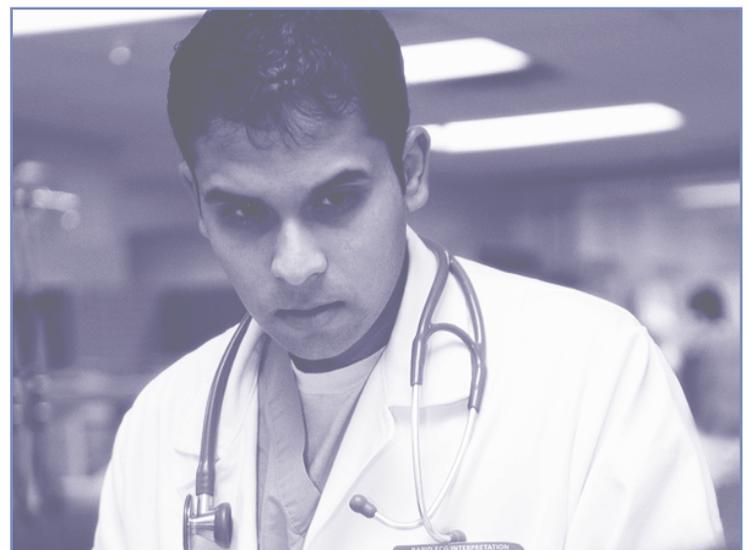
Be a full-time or part-time student (no less than six (6) units) in a California accredited school.

Immediately following graduation, complete a one (1) year service obligation working in a MUA of California providing direct patient care on a full-time basis (40 hours per week) in your field of study.

OR

Immediately following graduation, complete 100 volunteer work hours for every \$4,000 scholarship or 150 volunteer work hours for every \$4,500 scholarship. Volunteer work must be providing direct patient care in an MUA.

Maintain a minimum cumulative GPA of 2.0 each year funds are received.



Application Instructions (cont.)



SUBMIT THE FOLLOWING

1. Completed Application

Complete all pages of this application. It must be completed, signed, and dated to be considered eligible.

2. Official Transcript(s) Related to Your Allied Healthcare Education

If you are a student in your first year of the program and your transcripts do not reflect your allied healthcare education, submit your most current transcript.

The transcript must be marked official by the school and delivered to the Foundation in a sealed envelope. The Foundation will not accept unofficial transcripts, copies or print outs of transcripts, or transcripts in a broken envelope.

3. Personal Statement (Part D of the Application)

Attach your personal statement to the application. Your statement must be typed and no more than two (2) pages. Restate and number each question along with a comprehensive response to each question. Personal statements that lack detail may be considered incomplete and therefore ineligible.

4. Two Professional Letters of Recommendation

Letters of recommendation must be dated within six (6) months of the application deadline. The letters must be on letterhead or include the author's title, name of employer, mailing address, and phone number. It is recommended that at least one (1) letter be from a faculty member. Letters of recommendation that confirm community service are encouraged.

5. Graduation Date Verification Form

The program director or a faculty member authorized to sign on the director's behalf must sign this form. The Graduation Date Verification Form is enclosed as part of the scholarship application. Students can also download this form from the Foundation's website at www.healthprofessions.ca.gov.

6. Student Aid Report (SAR)

Students must submit the final 2008-2009 SAR. The SAR must indicate the student's expected family contribution (EFC). The FAFSA is available from all college financial aid offices and is also available on the Internet at www.ed.gov/offices/OPE/express.html. **DO NOT SUBMIT FAFSA.**

OR

2008 Federal Tax Return and all W-2s - Students who do not apply for financial aid must submit complete and signed copies of their 2008 Federal Tax Return and all W-2s. **DO NOT SUBMIT STATE TAX RETURNS.**

APPLICATION SUBMISSION

Applications must be postmarked by the deadline. In order to be reviewed, each part of the application must be completed. All supporting documentation must be submitted by the appropriate deadline. The Foundation will not notify applicants if their application is received incomplete. Applicants are urged to contact the Foundation at (800) 773-1669 prior to the final filing date to verify if their application was received complete. Do not bind or submit applications in a loose-leaf binder.

NOTIFICATION OF AWARDS

The Foundation will notify applicants of their application results within 120 days of the final filing date.



For additional information on how to complete this application, please visit the Foundation's website to access Frequently Asked Questions, a technical assistance call and a powerpoint presentation.

SPRING POSTMARK DEADLINE: MARCH 24, 2009

FALL POSTMARK DEADLINE: SEPTEMBER 11, 2009

Submit applications to:
Health Professions Education Foundation
Allied Healthcare Scholarship Program
400 R Street, Suite 460
Sacramento, CA 95811
(800) 773-1669 or (916) 326-3640

Application

_____,
Last Name

First Name



Please refer to the application instructions when completing the application. Complete all pages of the application form, and make sure all supporting documents are submitted with your application. All documents must be postmarked by the application deadline. Late or incomplete application packets will not be evaluated.

Please enter the scholarship amount you are requesting (up to \$4,000 or \$4,500): _____

PART A - PERSONAL INFORMATION

Please type or print your answers legibly in the space provided

Mr.	Mrs.	Ms.	Dr.	Last Name:	First Name:	Middle Initial:
CA Drivers License Number:					*Social Security Number:	
Mailing Address:						
City:				State:		Zip Code:
County:						
Permanent Address (if different than above):						
City:				State:		Zip Code:
County:						
Home Phone: ()				Date of Birth:		
Cell Phone: ()				E-mail Address:		
Work Phone: ()				Gender: Male Female	Marital Status (Optional): Unmarried Married	
Are you a citizen or permanent resident of the U.S.? Yes No				Are you a California resident? Yes No		
Number of dependents other than self and spouse (as declared on tax returns or student aid report):						
Which best describes your ethnic background:						
African American		Caucasian		Native American		
Asian American		Hispanic/Latino		Pacific Islander		
Other (Please specify) _____						
If Native American, please specify tribal affiliation and submit verification: _____						

PERSONAL INFORMATION NOTIFICATION

The Information Practices Act of 1977 and the Federal Privacy Act require this program to provide the following to individuals who are asked by the Office of Statewide Health Planning and Development, Health Professions Education Foundation to supply information: The principal purposes for requesting personal information are for verification of identification, establishment of eligibility and program administration. Program regulations (Chapter 14 of Title 22 of the California Code of Regulations, Sections 97701 et seq.) require every individual to furnish appropriate information for application to the Allied Healthcare Scholarship Program. All requested information is required unless it is specifically identified as voluntary. Failure to furnish this information may result in the return of the application as incomplete. An individual has a right of access to records containing his/her personal information that are maintained by the Office of Statewide Health Planning and Development, Health Professions Education Foundation. The person responsible for maintaining the information is the Program Director, Health Professions Education Foundation, 400 R Street, Suite 460, Sacramento, CA 95811, (916) 326-3640. The Foundation may charge a small fee to cover the cost of duplicating this information.

*MANDATORY DISCLOSURE OF U.S. SOCIAL SECURITY NUMBERS

Disclosure of your U.S. Social Security Number is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42USCA 405(c)(2)(C)) authorize collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code, or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number your application will not be processed AND you will be reported to the Franchise Tax Board, which may assess a \$100 penalty against you.

FOR OFFICIAL USE ONLY

Recd:	Compl / Inc:	Omitted: App Pgs	EDR	Per State	LoR	Other
App Inquiry: (- -) (- -)	HPEF Contact:		for:			
Input By:	MUA: Yes / No	CT#:				
Reviewed By:	Comments:					

Applicant's Name: _____

PART B – COMMUNITY BACKGROUND

1. Have you lived in an economically disadvantaged background (income below the federal poverty level, low income, subsidized income, qualified for public programs, lived in rural, inner city or medically underserved area) for at least two (2) years? Yes No

If yes, please check the appropriate range of years.

2-5 years 6-10 years 11 or more years

PART C – FLUENCY

1. List any languages in which you are fluent. This must be verified by the applicant's Graduation Date Verification Form.

1st language: _____

2nd language: _____

3rd language: _____

PART D – PERSONAL STATEMENT

Attach your personal statement to the application. Your statement must be typed and no more than two (2) pages. Restate and number each question along with a comprehensive response to each question. Personal statements that lack detail may be considered incomplete and therefore ineligible.

1. What kind of work would you like to do immediately after graduation?
2. What kind of work do you think you'll be doing in five (5) years?
3. What are your professional goals for the next five (5) to ten (10) years, as they relate to your allied healthcare profession?
4. Describe any community service, volunteer activities, or club memberships within the past two (2) years. Please attach any letters of recommendation you may have. Do not include experience for which you received academic credit.
5. Briefly describe your family background including: your parent's or guardian's occupation, marital status, family size such as number of dependents including yourself, where you were raised, first in family to attend college, English as a second language and any other factors that help describe your family socio-economic situation.
6. Describe how your background is relevant to your interest in pursuing an allied health career. Do you see your background as an advantage, disadvantage or both?

PART E – PROGRAM OF ENROLLMENT

1. Please indicate which program you have enrolled or been accepted to:

Diagnostic Medical Sonography	Physical Therapy
Clinical Laboratory Science	Physical Therapy Assistant
Medical Assistant	Radiation Therapy Technology
Medical Imaging	Radiologic Technology
Medical Laboratory Technology	Respiratory Care
Nuclear Medicine Technology	Social Work
Occupational Therapy	Speech Therapy
Pharmacy	Surgical Technician
Pharmacy Technician	Ultrasound Technician

PART F – QUESTIONNAIRE

1. Are you a previous awardee of the Foundation? Yes No
If yes, please enter the contract # _____

2. Do you currently owe a service obligation to another entity?
Yes No

"Service Obligation" means the contractual obligation agreed to by the recipient of a scholarship where the recipient agrees to practice their profession for a specified period of time in or through a designated facility.

Where did you hear about the Allied Healthcare Scholarship Program?
(Check all that apply)

Work (employer or co-worker)	Friend/Acquaintance
TV	Radio
Other Website	Foundation Website
Newspaper or publication (please specify) _____	Advertisement
Organization or Affiliation (please specify) _____	
Other Source (please specify) _____	

Where did you receive the Allied Healthcare Scholarship Program application? (Check only one)

Program Director/Instructor	Foundation Office
Foundation Website	Other Website
Work (employer/co-worker)	Friend/Acquaintance
Other (please specify) _____	

PART G – APPLICATION CERTIFICATION

I certify that all information in this application is true and accurate to the best of my knowledge. I authorize the Health Professions Education Foundation (Foundation) to verify any information submitted as part of this application. I understand that falsification of information contained in this application will disqualify my application and the respective licensing Board will be notified. I understand that if falsification is discovered after I have been awarded or if I breach my contract, I will be required to repay all funds awarded, plus interest and administrative fees. I understand that once submitted my application and supporting documents become the property of the Foundation. I also understand that my personal statement becomes the property of the Foundation and may be used, including but not limited to, advertising/marketing, program reports, newsletters, and other publications.

Last Name: _____

First Name: _____ Middle Initial: _____

Applicant's Signature: _____

Date: _____

APPLICATION CHECKLIST

1. Completed Application
2. Official Transcript(s) related to your allied health education
3. Personal Statement
4. Two (2) Professional Letters of Recommendation
5. Graduation Date Verification Form
6. 2008-2009 Student Aid Report or 2008 Federal Tax Return and all W-2s

Graduation Date Verification Form

**ATTENTION! The completed form must bear an original ink signature.
Photocopies and faxed copies of the completed form are not acceptable.**

FORM TO BE COMPLETED BY THE PROGRAM DIRECTOR OR AN APPROPRIATE DESIGNEE
(The person signing this form may not be related to the applicant by blood, marriage, or adoption)

Student's Last Name: _____ First Name: _____ Middle Initial: _____

Allied Healthcare Program Enrolled: _____

School Name: _____

School Mailing Address: _____

City: _____ County: _____ State: _____ Zip Code: _____

Year Entered (Month / Year): _____ Expected Graduation Date (Month / Year): _____

Enrollment Status: F/T or P/T # of units currently enrolled: _____

Current GPA: _____

Please comment on the student's performance and potential for academic success.

I can verify that the applicant can fluently speak the following language(s):

1st language: _____

2nd language: _____

3rd language: _____

Name: (Please Print) _____

Signature: _____

Title: _____

Phone Number: _____

Fax Number: _____

Email: _____

Date: _____

Attach Business Card Here



HEALTH PROFESSIONS EDUCATION FOUNDATION

Giving Golden Opportunities

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www.healthprofessions.ca.gov
(800) 773-1669

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