

THE DEADLINE FOR APPLICATIONS IS MONDAY, MAY 23, 2022.

Please make sure you have submitted your application with the required additional materials before then.
Applications can be submitted by mail or through email.

For more information, please visit www.cchp-wi.org/scholarships
Please call us at (414) 266-6157 if you need assistance

PLEASE TYPE OR CLEARLY PRINT YOUR ANSWERS.

1. Name (<i>First, MI, Last</i>):	
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 Children's Community Health Plan? <input type="checkbox"/> I am an enrollee. <input type="checkbox"/> 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: _____ <input type="checkbox"/> 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.	<p>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.</p> <p> <input type="checkbox"/> Enrolled Name of higher education institution: _____ <input type="checkbox"/> Accepted Name of higher education institution: _____ <input type="checkbox"/> Applied Name of higher education institution: _____ </p> <p>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.</p>		
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.		
	<i>Position</i>	<i>Employer</i>	<i>Dates of Employment</i>
			<i>Duties</i>
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 500 words or less.** Please submit your responses on the additional pages (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 Children's Community Health Plan? (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 Children's Community Health Plan.)
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?

Essay Question 1: How have you benefited from the medical care, services and/or supports that have been provided by Children's Community Health Plan? (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 Children's Community Health Plan.)

Essay Question 2: How will your studies further your career in the health care and/or human/social services fields?

Essay Question 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 Children's Community Health Plan 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 Children's Community Health Plan 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 **May 23, 2022** to be considered.
