



HEALTH PROFESSIONS
Scholarship Program



METROWEST
COMMUNITY
HEALTH CARE
FOUNDATION

What is the MetroWest Community Health Care Foundation?

The MetroWest Community Health Care Foundation is an independent health care philanthropy serving the unmet health needs of the twenty-five communities in the Massachusetts MetroWest Area. The Foundation was established in 1999, as a result of the 1996 sale of the MetroWest Medical Center (Framingham Union and Leonard Morse Hospitals). The Foundation's programs include annual grantmaking, scholarships, health education forums and other activities designed to improve the health of those who live and work in the MetroWest Area.

What types of scholarships are available?

Scholarships are available for the following nursing, medical and clinical programs:

Nursing Programs

- Certified Nursing Assistant (CNA)
- Licensed Practical Nurse (LPN)
- Registered Nurse (RN)
- Baccalaureate of Science in Nursing (BSN)
- Certified Nurse Midwife (CNM)
- Masters of Science in Nursing (MSN)
- Nurse Practitioner Certification (NPC)
- Other related nursing specialty certifications

Medical and Clinical Programs

- Acupuncture
- Chiropractic
- Dental
- Emergency Medical Technician/Paramedic
- Medical Lab
- Medicine
- Occupational Therapy
- Optometry
- Pharmacy
- Phlebotomy
- Physical Therapy
- Physician Assistant
- Podiatry
- Psychology (Masters and above)
- Public Health (Masters and above)
- Radiology
- Registered Dietician/Nutritionist
- Respiratory Therapy
- Social Work (BSW and above)
- Speech
- Surgical Technology

How are grantees selected?

Scholarship awards are based on financial need, academic performance, and demonstrated motivation and character to obtain a formal education in a nursing, medical or clinical profession.

All scholarships are reviewed by the Foundation's Scholarship Committee, which is made up of representatives of the Foundation's Framingham Union Grants Panel, Leonard Morse Grants Panel, and Distribution Committee. The recommendations of the Scholarship Committee require approval by the Foundation's Board of Trustees. All decisions are made on an objective and nondiscriminatory basis and are final.

Applicants may also be asked to attend a brief interview.

What are the eligibility requirements?

Applicants must be a resident or work at least 15 hours per week on a regular basis in one of the following twenty-five towns: Ashland, Bellingham, Dover, Framingham, Franklin, Holliston, Hopedale, Hopkinton, Hudson, Marlborough, Medfield, Medway, Mendon, Milford, Millis, Natick, Needham, Norfolk, Northborough, Sherborn, Southborough, Sudbury, Wayland, Wellesley, or Westborough.

Applicants must be enrolled in a nursing or formal medical or clinical program at an accredited institution.

How do I apply?

Applicants must complete the attached confidential Scholarship Application form and submit all required attachments (*see Part 5 for the list of required attachments*) to:

MetroWest Community Health Care Foundation
c/o Cathy Glover, Program Officer
161 Worcester Road, Suite 202
Framingham, MA 01701

Applicants must submit the Financial Aid Verification form to the appropriate personnel in the financial aid office of their educational institution. The completed form must be returned to the applicant in a sealed envelope or mailed directly to the Foundation.

Applicants must submit the Student Evaluation form to a faculty member of their educational institution. The completed form must be returned to the applicant in a sealed envelope or mailed directly to the Foundation.

What is the scholarship amount available?

Scholarships are awarded for tuition fees only up to a maximum of \$2,000 per academic year and applicants may reapply on an annual basis.

All scholarship payments are made directly to the academic institution.

What is the deadline for submitting an application?

There is no deadline. Applications are reviewed as they are received and may be submitted at any time.

APPLICANT INFORMATION

▶ DATE _____

Name:

LAST

FIRST

M. I.

Address:

NO.

STREET

TOWN

STATE

ZIP

Phone Number:

DAYTIME

EVENING

Social Security Number:

Date of Birth:

Number of Dependents:

Marital Status (circle one):

SINGLE

MARRIED

DIVORCED

WIDOWED

U.S. Citizen (circle one):

YES

NO

If no, citizen of:

EMPLOYMENT INFORMATION

Employed By:

Address:

NO.

STREET

TOWN

STATE

ZIP

Phone Number:

No. of hours worked per week:

Job Title/Description:

Supervisor's Name:

SCHOOL INFORMATION

Name of Educational Institution Attending:

Address:

NO.

STREET

TOWN

STATE

ZIP

Status (circle one):

FULL TIME

PART TIME

Academic Year (circle one):

1ST

2ND

3RD

4TH

OTHER

Overall GPA:

Expected Year of Graduation:

Degree or Certification Program Enrolled:

INTENTIONS AFTER GRADUATION

Do you intend to practice in the MetroWest area upon completion of your academic program? (circle one):

YES

NO

If no, where do you intend to practice?

Type of Practice Setting Where You Intend to Work (i.e. Hospital/Clinic):

COMMUNITY SERVICE/ACTIVITIES

PART 2

Applicant Financial Information

	STUDENT	SPOUSE
Adjusted Gross Income (<i>List Individually</i>)	\$	\$
Total Cash, Savings & Investments (<i>excluding 401k or other retirement savings</i>)	\$	\$
Child Support Received	\$	\$
Monthly Mortgage/Rent Payment	\$	\$

I have applied for other scholarships, grants, loans or other forms of anticipated financial assistance as follows:
(*If not yet granted, mark (P) for pending and notify us when you have received a response.*)

Student loans outstanding (*circle one*): YES NO *If yes, amount outstanding \$*

UNUSUAL CONSIDERATIONS

Please describe any unusual family or personal circumstances you believe will affect your ability to contribute to your education.

PART 3**Parent's Information**

(Complete only if applicant is under 21 years old.)

Father's Name:

LAST

FIRST

M. I.

Address:

NO.

STREET

TOWN

STATE

ZIP

Mother's Name:

LAST

FIRST

M. I.

Address:

(IF DIFFERENT)

NO.

STREET

TOWN

STATE

ZIP

Parent's Current Marital Status (circle one):

SINGLE

MARRIED

DIVORCED

WIDOWED

	MOTHER	FATHER
Adjusted Gross Income (List Individually)	\$	\$
Total Cash, Savings & Investments (excluding 401k or other retirement savings)	\$	\$
Monthly Mortgage/Rent Payment	\$	\$

Number of Dependents in Household:

Dependents in College:

FOR ALL APPLICANTS

I understand that I must be a full or part-time student to receive a MetroWest Community Health Care Foundation (“Foundation”) scholarship. I understand that I must notify the Foundation IMMEDIATELY, IN WRITING, if my plans for this academic year vary from the nature of the program listed on the previous page. I understand that a change in my plans may make me ineligible for this scholarship.

Under the penalties of perjury, I do solemnly affirm that all information provided pertaining to this application, herein stated or provided separately, is true to the best of my knowledge and belief. Although confidentiality of information provided is expected of the MetroWest Community Health Care Foundation, I hereby authorize the Foundation to investigate in any manner which it, in its discretion, deems necessary to determine the accuracy of the statements made in this application and my eligibility for aid. I accept the responsibility for notifying the Foundation of any change from that stated in this application in my financial status, nature of course curriculum, change of school or career goal. I agree to make this notification immediately, in writing. I understand and agree that failure to do so may obligate me to return any scholarship granted to me or on my behalf by the Foundation.

SIGNATURE OF APPLICANT

SIGNATURE OF PARENT OR GUARDIAN (REQUIRED IF APPLICANT IS UNDER 18)

In addition to the scholarship application, you must submit the following documents.

1. A copy of your current Student Aid Report (SAR). (Students must file for federal financial aid.)
2. Proof of residency.
3. A copy of your most recent income tax return. (*Students under the age of 21 must also submit a copy of your parents' most recent income tax return.*)
4. A copy of the tuition bill for which you are seeking funding.
5. A copy of your class schedule.
6. A photocopied course description from the academic institution you are attending and for which you are seeking funding.
7. A brief typed biography of your academic past and academic/professional goals.
8. A sealed copy of your transcript.
9. A sealed copy of the enclosed Financial Aid Verification form.
10. A sealed copy of the enclosed Student Evaluation form.
11. If you do not live in one of the 25 towns of the MetroWest service area, proof of employment must be supported by a copy of your most recent paystub and a letter from your employer on company stationery indicating your position and average weekly hours worked.

The Foundation reserves the right to request additional information that may be needed to support this application.

Financial Aid Verification

Name: _____
LAST FIRST M. I.

Address: _____
NO. STREET TOWN STATE ZIP

Social Security Number: _____

Scholastic Institution: _____ Program Enrolled: _____

TO BE COMPLETED BY FINANCIAL AID OFFICE

▶ Please complete this form and return it to the student in a sealed envelope or mail directly to the Foundation.

Cost of Attendance		Estimated Family Contribution	
Tuition and Fees	\$	Parent Contribution	\$
Room and Board	\$	Student Contribution	\$
Books and Supplies	\$	Total Estimated Family Contribution	\$
Personal	\$	Estimated Financial Aid	
Transportation	\$		
Child Care	\$		
Other	\$		
Total Cost of Attendance	\$	Grants	\$
		Loans	\$
		Scholarships	\$

FINANCIAL AID OFFICER'S SIGNATURE _____ DATE _____

PRINT NAME AND TITLE _____ TELEPHONE _____

TO BE COMPLETED BY STUDENT

I hereby authorize _____ (NAME OF SCHOLASTIC INSTITUTION) to release the information requested above to the MetroWest Community Health Care Foundation.

STUDENT'S SIGNATURE _____ PARENT'S SIGNATURE (IF UNDER 21) _____ DATE _____



MetroWest Community Health Care Foundation

161 Worcester Road, Suite 202, Framingham, MA 01701 • tel: 508-879-7625 • www.mchcf.org • info@mchcf.org

Student Evaluation

Student's Name: _____

- To be completed by a faculty member of the nursing, medical, or clinical program. Please complete this form and return it to the student in a sealed envelope or mail directly to the Foundation.

Please rate the student on a scale of 1-5 on the areas below: (1=lowest; 5=highest) *Circle one response to each area.*

1. Student's commitment to the program:	1	2	3	4	5
2. Student's contribution to the program:	1	2	3	4	5
3. Student's abilities to cope with the demand of the program:	1	2	3	4	5
4. Student's academic achievements/abilities:	1	2	3	4	5

Appraiser's Signature: _____

Print Name: _____

Educational Institution: _____

Appraiser's Position: _____

Phone Number: _____

Additional Comments: _____



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