VDH-OHE LONG-TERM CARE FACILITY NURSING SCHOLARSHIP PROGRAM
2016 APPLICATION FOR REGISTERED NURSES (RNs), LICENSES PRACTICAL NURSES (LPNs) AND CERTIFIED NURSE AIDES (CNAs)

APPLICATION CHECKLIST AND REQUIREMENTS

This checklist must be reviewed thoroughly and submitted as part of a completed application. Incomplete applications will not be considered for award and failure to comply with any of these application requirements will result in the applicant being ineligible for award.

The Long-term care facility nursing scholarships is for students enrolled in undergraduate nursing programs. Undergraduate nursing programs are defined as those leading to a diploma, an associate degree, or baccalaureate degree in nursing and include Registered Nurses (RNs), Licensed Practical Nurses (LPNs) and Certified Nurses Aides (CNAs). Under the law, all scholarship awards are made by an Advisory Committee appointed by the State Board of Health. The Office of Health Equity (OHE) of the State Health Department serves as the staff element to the Advisory Committee and has no role in the determination of scholarship recipients. The basis for determining scholarship recipients is established by the Advisory Committee with due regard given to scholastic attainment, financial need, character, and adaptability to the nursing profession.

☐ Applicant must be a United States Citizen , National, hold an immigration visa or classified as a political refugee as verified by a social security number included in the application. **Persons with a temporary or student visa are not eligible**.

☐ Applicant must be a resident of the State of Virginia for at least one year**.** Verification provided must prove that the applicant has lived in VA for at least one year (ex. Renewal date on driver's license, previous year on voter registration card, motor vehicle registration/employment records/deed of property/ sources of financial support, etc if they reflect multiple years). Please provide one of the following appropriate forms of verification: 1.) State Income Tax record or statement 2.) Driver's license with renewal information 3.) Voter registration card 4.) Motor vehicle registration 5.) Employment record 6.) Ownership of real property 7.) Financial support records.

☐ Applicant must attach a one page Narrative Summary. **"Section 7-Narrative Summary" must be printed at the top of the page. The applicant should sign and date the bottom of the page. (The Narrative Summary will not be accepted if not submitted as stated above.) In one page or less**, the summary must briefly explain the significance of the Long-term care facility nursing scholarship in pursuing his/her educational goals, any school/community activities, and any skill-set that is pertinent to the nursing profession. It is important that the applicant consider including plans for professional practice in Virginia following graduation. **If the Narrative Summary exceeds the one page limit, it will not be accepted**.

☐ Applicant must be accepted to or enrolled in a school of nursing in the State of Virginia which is approved by the State Board of Nursing. The applicant must have the Dean/Director/Chair of the Applicant's School of Nursing complete **Section 8** of the application, provide an **original signature** and have it returned to him/her to be submitted with the application. **Section 8 will not be accepted if it is not submitted with the application**

☐ Applicant **must attach an official transcript** of grades from all schools attended. **The transcript will not be accepted if it is not submitted with the application**. The applicant must demonstrate a cumulative grade point average (GPA) of at least 2.5 if currently enrolled in and attending a nursing program.

☐ Applicant must demonstrate financial need verified by a Financial Aid Officer/authorized person. The applicant must file one or more of the following: 1) Financial Aid Form (FAF) of the College Scholarship Service 2) the Family Financial Statement (FFS) of the American College Testing or 3) the Free Application for Federal Student Aid (FAFSA) with the institution they are attending or will attend for determination of financial need. The recommendation of the Financial Aid Officer must be based upon one of the three above referenced need analysis documents and must include a specific dollar amount determined to be the applicant's financial need. The Financial Aid Officer/Authorized Person must provide **original signatures** in **Section 9** of the application.

☐ **Applications must be typed and have all appropriate documents attached**. Applicants are advised to keep a copy for their records. Application open period is **May 1 to June 30**. Applications are not accepted prior to May 1st, and must be **postmarked by June 30th.** Please mail completed applications to:

Virginia Department of Health - Office of Health Equity (VDH-OHE)
ATTN: Workforce Incentive Programs
109 Governor St., Suite 714 West Richmond, Virginia 23219
If you have any questions, please contact The Office of Health Equity at 804-864-7435.

SECTION 1 – PERSONAL DATA

Date of Application: _____

Legal Name: _____
Last First MI Maiden

Preferred Name: _____

Address: _____
Street Address

_____
City State Zip

Day Phone Number: _____ Evening Phone Number: _____

Email Address: _____

Social Security Number: _____ Sex: Please Select One

Date of Birth and Age: _____ Place of Birth: _____

Race/Ethnicity: Please Select One Other: _____

How long have you been a resident of Virginia? _____

Do you have an active military service obligation? Please Select One

Congressional District: (Please check with your voter registration office or visit http://nationalatlas.gov/printable/congress.html)

Are you a high school graduate? Please Select One Do you possess a GED? Please Select One

Are you an RN, LPN or CNA? Please Select One If you selected yes, which one(s)? _____

Have you ever received a Nursing Scholarship from VDH-OHE? Please Select One

If yes, in what year(s) and which one? _____

If you had a different name when you applied previously, please provide it here: _____

What school of nursing were you attending during that time? _____

Do you speak another language? Please Select One If yes, please list: _____

ALTERNATE CONTACT PERSON (OTHER THAN APPLICANT)

Name: _____
Last First MI

Address: _____
Street Address

_____ _____ _____
City State Zip

Phone Number: _____ Relationship to Applicant: _____

SECTION 2 – NURSING EDUCATION

School of Nursing: _____

Student Identification or
Social Security Number: _____

Address: _____
Street Address

_____
City State Zip

Phone Number : _____

☐Full-time Student: ☐Part-time Student: If part-time, how many credit hours are you taking? _____

Have you transferred to this school from another nursing program? Please Select One

Name of previous school: _____

Date of enrollment in present Nursing Program: Month _____ Day _____ Year _____

Expected date of graduation: Month _____ Day _____ Year _____

NURSING PROGRAM LEVEL:

Please check the program type and current level. Specify level in September.

☐ CNA ☐LPN ☐ AAS, RN ☐BSN ☐ other _____

Program	Current Level	Level in September
Please Select One	Please Select One	Please Select One

SECTION 3 – PRIOR EDUCATION

Please check the program types that you have successfully obtained.

☐ CNA ☐LPN ☐ AAS, RN ☐BSN ☐ other _____

Current License:_____Current License Number:_____

	School	Diploma/Degree	City and State	Dates of Attendance	Reason for Leaving
1.				to	
2.				to	
3.				to	

SECTION 4 – WORK EXPERIENCE

☐ *Check here if you have never been employed, and skip to Section 5*

	Position	Name of Employer	City and State	Dates of Employment	Reason for Leaving
1.				to	
2.				to	
3.				to	

SECTION 5 – OTHER HEALTH-RELATED AND/OR CIVIC EXPERIENCES

☐ *Check here if you have never been involved in any health related and/or Civic Activities, and skip to Section 6*

	Position	Organization	City and State	Dates of activities
1.				to
2.				to
3.				to

SECTION 6 – OTHER FINANCIAL ASSISTANCE

Are you receiving any other type of financial aid for the upcoming school year? Please Select One

Please indicate:

SECTION 7 – NARRATIVE SUMMARY (Must submit as an attachment on a separate sheet)

Briefly explain, *in one page or less*, the significance of the Long-term care facility nursing scholarship in pursuing your educational goals. Also, include school and/or community activities as well as any skill-set that is pertinent to your profession. It is important that you consider including plans for professional practice in Virginia following graduation. Applicant **must** label the top of the attached sheet **"Section 7-Narrative Summary"**, print name, provide an original signature, and the current date. **If the Narrative Summary exceeds the one page limit, it will not be accepted**.

SECTION 8 – SCHOOL OF NURSING RECOMMENDATION

To be completed by the Dean/Director of the School of Nursing

1. Name of applicant: _____
2. Student Identification or Social Security Number: _____
3. This applicant is: Please Select One
4. Date of entrance: Month Year
5. During this award period, the applicant will be a: Please Select One
6. *If student is currently enrolled in your Nursing Program, please provide a cumulative grade point average of current nursing courses. Applicants must have at least a 2.5 cumulative GPA in Required Nursing Courses, electives should not be considered in* GPA: List GPA _____

   Source of computing GPA: Please Select One If other, please specify:
7. Please provide a brief recommendation (in 1,600 characters or less) based on the student's scholastic attainment, character, need, adaptability, and/ or other attributes.

Please provide an original signature from authorized personnel.

I recommend _____ for a Long-term care facility nursing scholarship award.
Full Name of Applicant

Name of Authorized Personnel Completing This Section	Title
Signature	Date
Full Name of School of Nursing	Phone Number E-mail Address

SECTION 9 – FINANCIAL NEED RECOMMENDATION

To be completed and signed by the Financial Aid Officer or Program Director

This section must include a monetary recommendation. The Long-term care facility nursing scholarship is a need-based aid program; therefore, the amount recommended must be documented by one of the accepted uniform methodology needs analysis systems. Please use the most recent needs analysis on file for this student to recommend the amount of scholarship required to meet need, after taking into consideration other financial aid already received by the applicant.

1. Applicant Name: _____

2. Student Identification or Social Security Number _____

3. **Student Costs and Resources:**
   Student Aid Budget for Applicant _____
   Expected Family Contribution (EFC) _____
   Financial Aid Received (excluding loans) _____
   Remaining Need _____
   Cost of Program for One Year
   (including tuition, fees, books, uniforms, etc.) _____

4. **Scholarship Recommendation:**
   Awards for undergraduates shall not be less that or exceed $2,000 annually. The Long-term care facility nursing scholarship committee will not make an award that exceeds the financial aid officer's recommendation, listed above.

   After reviewing the applicant's financial situation, I recommend a Long-term care facility nursing scholarship award of **$2000**

If your recommendation is less than both the "remaining need" above and the maximum allowable award amount listed above, please explain:

5. **Needs Analysis Method Used:**
   Please indicate which of the following methods was used in determining the applicant's financial need and the academic year for which the form was filed. (Financial Aid Officers are encouraged to use the need analysis for the year in which the student is applying for assistance.)

☐ CSS	☐ ACT	☐ PELL	☐ FAFSA	Academic Year: 2016 to 2017

6. **Please specify any extenuating circumstances which may have influenced your recommendation.**

Please provide an original signature from authorized personnel.

Name of Financial Aid Officer/Authorized Personnel (Please Print) _____ Phone Number _____

Signature of Financial Aid Officer/Authorized Personnel _____ Date _____

E-Mail Address: _____

SECTION 10 – CERTIFICATION STATEMENT

I, the undersigned, hereby certify that all of the information on this scholarship application is true and complete to the best of my knowledge. I realize that information from this application will be used to determine scholarship eligibility. If asked by the Nursing Scholarship Advisory Committee, I agree to provide documentation verifying any information on this application. I have read and accept the conditions of the Long-term care facility nursing scholarship.

Signature of Applicant _____ Date _____

Full Name (Please Print) _____

Any persons dissatisfied with the award or denial of an application to become a scholarship participant must notify staff of the Nursing Scholarship Advisory Committee within 14 days of receiving notification of the award or denial of an application.

For marketing purposes, how did you learn about this scholarship opportunity? _____

Thank you for your interest in this program!

Staff Record Only: ☐ *Application complete upon receipt* ☐ *Additional information requested*