**SCHOLARSHIP APPLICATION - Intervention**

Client Name _____ Date of Birth_____

Parent/Caregivers _____ Email _____

Address_____

Best phone # to reach you: _____ home/work/cell

Clinical Faculty/Speech-Language Pathologist assigned to your family: _____

Type of therapy (individual, group, both): _____

**Do you have insurance that will pay for Speech-Language Services at the Schiefelbusch Clinic? (circle one)**

YES NO I have insurance but don't know if they will pay for services

**INCOME INFORMATION – Based on the size of your family (left column), please circle the correct income range for your family.**

2018 Federal Poverty Guidelines (FPG)

| Family Size | <300% Poverty | 300-450% of Poverty | >450% Poverty |
|---|---|---|---|
| 1 | <$36,420 | **$35,010-52,515** | **>$52,515** |
| 2 | <$49,380 | **$47,190-70,785** | **>$70,785** |
| 3 | <$62,340 | **$59,370-89,055** | **>$89,055** |
| 4 | <$75,300 | **$71,550-107,325** | **>$107,325** |
| 5 | <$88,260 | **$83,370-125,055** | **>$125,055** |
| 6 | <$101,220 | **$95,910-143,865** | **>$143,865** |
| 7 | <$114,180 | **$108,090-162,135** | **>$162,135** |
| 8 | <$127,140 | **$120,270-180,405** | **>$180,405** |

Special circumstances we should know about _____

_____

_____

**REQUEST**:

Partial Scholarship _____ Full Scholarship _____
(Amount requested)

I /We certify that the above information is accurate.

_____ _____
Signature Date

*Committee Decision:* *For Office Use Only*

_____Award Scholarship Kind _____ Amount _____

_____On Waiting List for Scholarship

_____Sliding Scale

_____Other, _____

_____

Previous Scholarship awards: Semester/s and amount:_____

Number of Semesters Received:_____

Date: _____ Signature:_____

Date applicant notified: _____