**Scholarship Program**

**Guidelines**

Community Partners, the charitable arm of Shawnee Family Health Center announces the 2017-2018 **Community Partners Foundation *Scholarship Awards Program.*** Under the Program, two $500.00 scholarships will be awarded to **college juniors, seniors or graduate students** who are enrolled in a program designed to prepare a person to work within the mental health field. This would include, but not be limited to, the following types of programs: social work, counseling, psychology, counseling education, psychiatric nursing or psychiatry.

Program Guidelines

\* Applicants must be a resident of or work in Adams, Lawrence or Scioto Counties.

\* Be enrolled in an accredited college or university in an applicable field

\* Have a minimum GPA of 3.0

\* Awarded funds can be used for tuition, books, or other education related expenses but will be paid directly to the school.

\* Completed applications must be postmarked on or before March 31

\* Completed applications include:

* Postmark date on or before the deadline
* Completed and signed application
* Essay
* Statement of Support from Advisor or Department Chair
* Transcript from your school (this can be the one from your electronic student account; does not have to be from the registrar)

Mail one copy of a completed application package to: Community Partners of Shawnee Mental Health Attn: Scholarship Committee 901 Washington Street

Portsmouth, OH 45662

The applications will be reviewed and recipients selected by a committee consisting of Community Partners of Shawnee Mental Health board of directors. Recipients will be notified by mail by May 31st and funds distributed to the recipients applicable school August 1st.

Applications may be downloaded from the Shawnee Family Health Center website at [www.shawneemhc.org](http://www.shawneemhc.org)

Please submit any questions to: [c.holstein@shawneemhc.org](mailto:c.holstein@shawneemhc.org)

**Scholarship APPLICATION**

|  |  |  |
| --- | --- | --- |
| Please **type** or **print** legibly | | |
| 1. | Last Name: | First Name: |
| 2. | Mailing Address Street:City: State: Zip: | |
| 3. | Daytime Telephone Number: ( )  Email Address: | |
| 4. | Are you currently working in the mental health field? YES NO | |
| 5. | If you answer “yes” to item 4, please indicate where you work and your current position: | |
| 5. | Cumulative Grade Point Average (GPA): \_\_\_\_\_\_\_\_\_\_ (On a 4.0 scale)  Attach proof of GPA. Your most recent school transcript is required. | |
| 6. | Are you the first person in your family to go to college: YES \_\_\_ NO \_\_\_\_ | |
| 7. | Name and location of College or University attending: | |
| 8. | School address: | |
| 9. | Your School Student ID Number | |
| 10. | Field of study | |
| 11 | Degree you are currently pursuing: ❒Bachelors ❒Masters ❒M.D. ❒Psy.D. ❒Other | |

**12. On a separate sheet please write a brief essay (250 - 500 words) addressing the item below:**

Describe your career goals and why you have chosen to pursue a degree within the social services field in Appalachia.

### STATEMENT OF ACCURACY FOR STUDENTS

I hereby affirm that all the above stated information provided by me is true and correct to the best of my knowledge. I also consent that if chosen as a scholarship winner my picture may be taken and used to promote the Foundation’s scholarship program. (Winner may waive photo due to unusual or compelling circumstances.)

I hereby understand that if chosen as a scholarship winner, it is my responsibility to remit to the Foundation the appropriate information for my scholarship to be paid directly to my educational institution

I hereby understand I will not submit this application without all required attachments and supporting information. Incomplete applications or applications that do not meet eligibility criteria will not be considered for this scholarship.

**Signature of scholarship applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**STATEMENT OF SUPPORT BY ADVISOR OR DEPARTMENT CHAIR**

I hereby affirm that this application meets the criteria set forth by this scholarship program and that I support this application to Community Partners of Shawnee Mental Health Center.

Advisor Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

College or University:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact information (email and phone):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Advisor/Chair Signature : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FOR COMMUNITY PARTNER USE ONLY**

**Checklist**

\_\_\_\_Postmarked on or before March 31st

\_\_\_ Application

\_\_\_ Essay

\_\_\_ Advisor/Chair signature

\_\_\_ School Transcript

**MAIL COMPLETE APPLICATION PACKAGE TO THE FOUNDATION AT:**

**Community Partners of Shawnee Mental Health Center**

**Attn: Scholarship Committee**

**901 Washington Street**

**Portsmouth, OH 45662**

**REMINDER:**

**The deadline for this application to be postmarked the Foundation’s Office is:**

**March 31st NO EXCEPTIONS!**