Lexington Hearing & Speech Center

SCHOLARSHIP APPLICATION

Lexington Hearing & Speech Center is pleased to offer our families a scholarship tuition assistance program. Our ability to offer scholarships is dependent upon the financial condition of the Center and available scholarship funds which LHSC receives through community grants and individual donations.

ELIGIBILITY

Children are eligible for tuition scholarships if they meet the following criteria:

1. The child has a diagnosed hearing and/or speech disability and the family agrees to use LHSC's audiologist and speech therapists
2. The child enrolls in Head Start program
3. The child qualifies for Child Care Assistance funding (CCAP)*
4. If your child has hearing loss of 55 Pure tone avg db hearing loss and greater, you will be expected to apply for the AG Bell Financial Assistance Fund. http://www.agbell.org/Tertiary.aspx?id=2102

*If any family exceeding income eligibility for CCAP believes that special circumstances affect their ability to pay full tuition, they may describe their situation on this application. You may be asked to provide a copy of the denial letter.

Eligible scholarship families with more than one child enrolled at LHSC may be awarded scholarships for each child (fill out one application for each child). Scholarship recipients should notify the Family Services Office if their financial situation improves midyear, lessening their need for assistance. Scholarship funds do not cover the enrollment fee, annual registration fee, late pickup fee, missed days not covered by CCAP, previously paid tuition or any other financial obligation to the Center. Scholarships are available for kindergarten and preschool education programs.

PARENT EXPECTATIONS

- Include a brief letter describing why the programs at LHSC will benefit your child
- Seek out non-monetary opportunities to support LHSC. Examples: attend and participate in the PTA, volunteer to help with a family event, volunteer to help in the office or volunteer with light handyman duties, etc…
- Complete an end of school-year review

CONFIDENTIALITY

Scholarship applications are kept strictly confidential. Financial information is reviewed only by the Center's Management Team. Scholarship decisions will be communicated to applicants by phone and mail.

MAIL SCHOLARSHIP APPLICATIONS TO:

Lexington Hearing & Speech Center Attn: Allison Kerschbaum, 350 Henry Clay Blvd., Lexington, KY 40502

OR

Deliver the packet to our Main Office on the 2nd floor at 350 Henry Clay Blvd. Lexington, KY 40502

APPLICATION CHECKLIST

- ☐ LHSC Scholarship Application and brief letter
- ☐ Documentation of child's diagnosis
- ☐ Proof of Child Care Assistance funding
- ☐ Head Start Application
- ☐ Proof of income (previous year's income tax return and two most recent pay stubs)

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SCHOLARSHIP APPLICATION

CHILD'S NAME:	DOB:
CHILD'S ADDRESS:	
PARENT/GUARDIAN:	PARENT/GUARDIAN:
ADDRESS: County: PHONE: HOME: _____ CELL: _____ WORK: _____ RELATIONSHIP: _____	ADDRESS: County: PHONE: HOME: _____ CELL: _____ WORK: _____ RELATIONSHIP: _____
CHILD LIVES WITH: _☐_MOTHER _☐_FATHER _☐_BOTH _☐_FOSTER _☐_OTHER	
FAMILY SIZE: _____ADULTS _____CHILDREN	
CHILD'S DIAGNOSIS:	
THERAPIES CHILD NEEDS/RECIEVES:	
ANNUAL HOUSEHOLD INCOME $ _____	
DO YOU OR ANYONE IN YOUR HOUSEHOLD RECEIVE ADDITIONAL FINANCIAL ASSISTANCE FROM ANY OF THE FOLLOWING--MONTHLY? UNEMPLOYMENT $_____ ALIMONY $_____ CHILD SUPPORT $_____ SOCIAL SECURITY $_____ OTHER $_____ SPECIAL NEEDS ADOPTION PROGRAM $_____	
PLEASE EXPLAIN ANY SPECIAL FINANCIAL CIRCUMSTANCES AFFECTING THE FAMILY'S BUDGET AT THIS TIME:	
HOW MUCH ARE YOU ABLE TO CONTRIBUTE FINANCIALLY TO YOUR CHILD'S TUITION: $_____ PER WEEK	
I HEREBY CERTIFY THAT ALL THE INFORMATION CONTAINED IN THIS APPLICATION IS TRUE AND CORRECT. IN ADDITION, I HAVE ATTACHED DOCUMENTATION OF MY CHILD'S DIAGNOSIS, CHILD CARE ASSISTANCE FUNDING, HEAD START APPLICATION AND PROOF OF INCOME. I ALSO UNDERSTAND THAT ANY MISREPRESENTATION OF THE INFORMATION CONTAINED IN THIS DOCUMENT DOES CONSTITUTE FRAUD AND I WILL, THEREFORE, BE REQUIRED TO REPAY ALL SCHOLARSHIP FUNDS. I UNDERSTAND THAT MY CHILD MUST NOT MISS MORE THAN FIVE (5) UNEXCUSED DAYS EACH MONTH AND THAT THE SCHOLARSHIP FUNDS DO NOT COVER MISSED DAYS NOT COVERED BY THE CHILD CARE ASSISTANCE PROGRAM.	
SIGNATURE OF PARENT/GUARDIAN:	
SIGANTURE OF PARENT/GUARDIAN:	
DATE:	

☐YOU MAY USE THE BACK OF THIS FORM FOR YOUR PERSONAL LETTER TO THE COMMITTEE