Youth Program Scholarship Form

* Must be a diagnosed child (ren) with hearing loss by an audiologist with proof of decibel loss or,
* Musthave a deaf or hard of hearing person in the immediate family that child communicates with.
* Adults: (over age 18) supporting the household, **TOTAL YEARLY INCOME** must be below DHHS requirements. ***(This does*** *not* ***need to be a government document – only a signed & dated document stating what you earn).***

**Scholarship Form**

1. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Application: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number or e-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Check all that apply:**\_\_\_\_\_\_ Yes, I have a child (ren) that has been diagnosed by an audiologist with proof of decibel loss or,

\_\_\_\_\_\_\_\_Yes, I have a deaf or hard of hearing person in the immediate family that the child communicates with.

\_\_\_\_\_\_\_\_Yes, I believe all the adults (over 18) supporting the household have a total yearly income that indicates hardship.

\_\_\_\_\_\_\_\_I have attached a signed & dated document stating my **TOTAL YEARLY INCOME and the TOTAL YEARLY EXPENSES from all adults supporting the household.**

 \_\_\_\_\_\_Yes, I agree to volunteer at KidSigns events.

1. Please explain why you would want your child (ren) to join this program and how you think your child will benefit from this program.

*Once we receive the application form, financial information, and explanation, we will put you into consideration for the scholarship. Please send all information to Deaf and Hard of Hearing Services c/o KidSigns, PO Box 8812, Kentwood, MI 49518 or fax to 616-732-7365, or email to* *datwood@deafhhs.org*

*Please see the back of the sheet for a survey. We need this information for our grants. We will keep this confidential. Thank you so much!*

**# of Family Members**

Deaf: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HoH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hearing: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***For Office Use Only*:**

**Received Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Received By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Approximation of Your Income**

* Less than $20,000
* $20,000 to $34,999
* $35,000 to $49,999
* $50,000 to $74,999
* $75,000 to $99,999
* $100,000 or above

**Gender**

* Male
* Female
* Both
* Neutral
* Prefer Not to Answer

**Ethnicity**

* Caucasian
* Black
* Latino/a
* Native American
* Asian
* Multiracial
* Prefer Not to Answer