

# The Auxiliary



Community Hospital of the Monterey Peninsula®

## Scholarship Application

PLEASE NOTE: AN INCOMPLETE APPLICATION WILL NOT BE CONSIDERED

(Type or Print clearly in blue or black ink only.)

Name \_\_\_\_\_, \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Last First M. I.

Date of Birth (mo/day/year) \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_  Married  Single  Male  Female

City \_\_\_\_\_ Are you a resident of Monterey County? \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Phone# (\_\_\_\_\_) \_\_\_\_\_ How many years? \_\_\_\_\_ Email \_\_\_\_\_

Have you ever been or currently a CHOMP Auxiliary Member?  No  Yes ▶ Member as:  Adult  Collegiate  Junior

**CURRENT HEALTHCARE PROGRAM:**  LVN  RN  BSN  MSN  MLT  Other: \_\_\_\_\_

Name of college \_\_\_\_\_ Currently enrolled in healthcare program? \_\_\_\_\_

Address \_\_\_\_\_ Spring '\_\_\_\_ Summer '\_\_\_\_ Fall '\_\_\_\_

City \_\_\_\_\_ Date program first started (mo/yr) \_\_\_\_/\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Phone# (\_\_\_\_\_) \_\_\_\_\_ Date of Graduation (mo/yr) \_\_\_\_/\_\_\_\_

**FINANCIAL AID STATUS: Have you applied for Financial Aid since starting this healthcare program?**

Please Note: If only receiving the CCPG (California College Program Grant), either of the letters below is acceptable stating this fact and giving the dollar amount waived.

**Yes** – Must attach a *copy* of the **Financial Aid Notification Award letter** from the Student Financial Services Ofc.

**No** – Must attach the **Form Letter**, completed by the Student Financial Services Office, stating the reason.

**Please list all other awards, scholarships, and financial aid you have received but not mentioned on above letters.**

Please give name of organization, date, and the amount received.

1. \_\_\_\_\_ 3. \_\_\_\_\_
2. \_\_\_\_\_ 4. \_\_\_\_\_

**LIST PREVIOUS COLLEGES ATTENDED:** (list most recent college first)

Name of College	What Year(s) Attended	Degree/Major
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

**DEPENDENTS You Support Financially:** (list name, age, and relationship)

Name	Age	Relationship
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

**EMPLOYMENT:**

Are you currently employed?  Yes  No

Employer \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone # \_\_\_\_\_

Job Title \_\_\_\_\_

Full-Time  Part-Time  Per Diem  Temp

Projected gross annual income \$ \_\_\_\_\_

Any other financial support?  Yes  No

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Their Employer \_\_\_\_\_

Employer's City & State \_\_\_\_\_

Employer's Phone # \_\_\_\_\_

Occupation or Job Title \_\_\_\_\_

Last year's (other) gross annual income \$ \_\_\_\_\_

**EMPLOYMENT HISTORY DURING PAST TWO YEARS:** (list most recent job first)

	Employer	Job Title	Dates	Weekly Hours	Hourly Wage
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____

**OTHER INCOME:** (enter amount received per month)

TANF (Temporary Asst. for Needy Families) \$ \_\_\_\_\_

Child Support \$ \_\_\_\_\_

Non-taxable Income or Benefits \$ \_\_\_\_\_

Other \_\_\_\_\_ \$ \_\_\_\_\_

**ASSETS:** (enter current amounts)

Checking Account \$ \_\_\_\_\_

Savings Account \$ \_\_\_\_\_

Investments (Stocks, Bonds, Mutual Funds, etc.) \$ \_\_\_\_\_

Other \_\_\_\_\_ \$ \_\_\_\_\_

**EXPENSES:** (enter amounts per month)

Live at Home (with parents)  Yes  No

Mortgage or Rent \$ \_\_\_\_\_

Car Payments \_\_\_\_\_

Insurance Payments \_\_\_\_\_

Credit Card Payments \_\_\_\_\_

Loan Payments \_\_\_\_\_

Food Expenses \_\_\_\_\_

Utility Expenses \_\_\_\_\_

Child Care Expenses \_\_\_\_\_

Other Expenses \_\_\_\_\_

**MONTHLY TOTAL** \$ \_\_\_\_\_

**COSTS OF HEALTHCARE PROGRAM:** (enter amounts spent for the current semester)

Tuition \$ \_\_\_\_\_

Books \_\_\_\_\_

Uniform \_\_\_\_\_

Insurance \_\_\_\_\_

Other / Misc \_\_\_\_\_

**SEMESTER TOTAL** \$ \_\_\_\_\_

*I certify that all information I have entered on this application is true and correct to the best of my knowledge, and that any deliberately false information can be cause for disqualification from the CHOMP Auxiliary Scholarship Program.*

Applicant's Signature

Today's Date