

Peninsula Health Care District
FINANCIAL AID LOAN FORGIVENESS PROGRAM
APPLICATION

Personal Information *Please type or print*

Name _____ Circle one: Single Married Divorced Widowed

Legal Address _____ City _____ Zip _____

Mailing Address _____ City _____ Zip _____

Home Phone _____ Other Phone _____

Social Security Number _____ Age _____ Birthdate _____

List any volunteer/community service work within the past three years _____

For Healthcare Employees only Circle One: Hospital / SNF / Doctors Office
 Job Title _____ Department _____

Hours Worked per week _____ Work Site _____

Date of Hire _____

Will your continue to work while in school? Yes No

Prior scholarships received from Mills or Peninsula Auxiliaries or Mills-Peninsula Hospital Foundations or the Peninsula Health Care District:

Source	Amount	Year

Academic Information

Presently Attending _____

Current grade level or total semester units completed _____ GPA _____

School planning to attend in the fall semester/quarter _____

Address _____ City _____ State _____ Zip _____

Student Status for the coming year: Full-time - # of Units _____ Part-time - # of Units _____

Expected Degree/Certificate/Major _____ Expected Date of Graduation _____

FINANCIAL STATEMENT
Confidential Information

Income: Please provide financial information (list monies you expect to receive from any source) as the award is based on financial need.

	Applicant	Spouse	Parents	Others	Total
Name					
Employer					
Length of Employment					
Annual Gross Income					
Other funding you expect					
Scholarships					
Grants					
Loans					
Financial Assistance					
TOTAL					

Expenses: Please list your Yearly expenses. Attach additional sheets if necessary. If the total income is less than the expenses, please explain the deficit on the back of this form. As this is a financial need scholarship, it is helpful for the committee to understand your situation. Thank You.

	Applicant	Spouse	Parents	Others	Total
Rent					
Mortgage					
Specify other extraordinary expenses: Child Care, etc.					
Medical					
TOTAL					

What is the number of dependents and ages supported by the income listed above? _____

ESTIMATED BUDGET FOR SCHOOL YEAR

PLEASE NOTE: The amount you list below should be for the school year funds are needed. Example: If you are attending Fall and Spring semesters of the funding year, the total amounts listed should be for both semesters. If you are attending only the Fall or only the Spring semester of the funding year, only show the amount needed for that semester.

	School Choice #1	School Choice #2	School Choice #3
Name of School			
Tuition/Fees			
Books			
Supplies			
Uniforms			
Dormitory (Room & Board at School <i>if living away from home</i>)			
Other Expenses (Explain)			
Total School Expenses	\$	\$	\$

Funds for School \$ _____

Family Contribution \$ _____

Student Savings \$ _____

Scholarships \$ _____

Loans \$ _____

Other \$ _____

Total Funds You Have \$ _____

Amount Needed \$ _____

Confidential Financial Statement

Father's Name _____

Income \$ _____

Mother's Name _____

Income \$ _____

Spouse's Name _____

Income \$ _____

Savings: \$ _____ Certificates of Deposit \$ _____

Other Income:

- Trusts \$ _____
- Social Security \$ _____
- Child Support/Alimony \$ _____
- Rental Properties \$ _____
- Stocks/Bonds \$ _____

Own Home? _____ Value \$ _____

Amount Owed on Mortgage \$ _____

Mortgage Payment \$ _____

If you do not own, monthly rent \$ _____

Special Financial Problems:

(Large debts, unemployment, medical expenses, etc.)

Please attach the latest completed Federal Tax Return (1040) and all supporting schedules (i.e., A, B, C, D, E, etc.)

The above statements are true to the best of my knowledge.

Signatures of student and parent or guardian:

_____ Date _____

_____ Date _____

Peninsula Health Care District

**ATTACH THIS FORM AS YOUR COVER SHEET WHEN
RETURNING YOUR APPLICATION**

NAME: _____

DATE SUBMITTED: _____

Please assure that your package is complete at the time of submission:

- Application
- Financial Statement
- Estimated Budget for School Year
- Vision Statement of Career Goals
- Transcripts from all schools attended in the past two years
- Two (2) Letters of Recommendations (first time applicants only)
- Most Recent Evaluation (Healthcare employees only)

If any of the above items are missing, please state reason why and when we can expect to receive:

* * * * *

(District Office Use Only)

