



## **SCHOLARSHIP ADMINISTRATION AND PROCEDURES**

### **Objective:**

To provide financial assistance through an annual scholarship award to a truck driver in pursuit of a post-secondary education.

### **Eligibility:**

Any professional truck driver, who can no longer drive due to a medical problem, who is applying or is enrolled to an accredited trade school, college or university. No limit to subject area.

### **Amount:**

\$10,000

### **Application process:**

Eligible students must complete the SCF Scholarship application which consists of the following:

- General Student Information
- Academic Information
- Letters of Recommendation
- Essay
- Financial Information
- Certificate of Understanding and Accuracy
- SCF application and medical release form

### **Administration:**

1. A scholarship committee will review all applications
2. All applications must be mailed directly to the St. Christopher Fund. P.O. Box 30763 Knoxville, TN 37930
3. The committee's recommendations stand
4. The committee will provide a short list of alternatives in the event an applicant becomes ineligible
5. Number and amount of scholarships are determined by the SCF Board of Directors during the annual budget process and are subject to change
6. Checks are paid directly to the school, bookstore, etc. No personal checks will be written.
7. Repeat applicants are allowed.



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**Timing:**

The scholarship application is available November 15<sup>th</sup>. Application deadline is March 1st. The winner will be announced at the Mid-America Truck Show on Saturday, March 24, 2012.

**Communication:**

The SCF provides a downloadable version of the application on its website. Call 865-202-9428 with any questions.



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**SECTION I – GENERAL STUDENT INFORMATION**

Applicant: \_\_\_\_\_  
Last Name MI First Name

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

Telephone: \_\_\_\_\_

Email: \_\_\_\_\_

**SECTION II – ACADEMIC INFORMATION**

High School:  
\_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Cumulative High School GPA: \_\_\_\_\_ Date Graduated: \_\_\_\_\_

Date High School Transcript Requested to be sent to SCF: \_\_\_\_\_

College:  
\_\_\_\_\_  
(if currently attending)

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Cumulative College School GPA: \_\_\_\_\_ Date Graduated: \_\_\_\_\_

Academic Major and Degree Sought: \_\_\_\_\_

Date College Transcript Requested to be sent to SCF: \_\_\_\_\_

Enrollment plans for 2012-2013: \_\_\_\_\_ Full-time \_\_\_\_\_ Part-time



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### **SECTION III – SUPPLEMENTAL INFORMATION**

List any academic or community activities in which you are (or have been) involved as well as any awards received. Note also any work experience, if applicable.

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### **SECITON IV – LETTER OF RECOMMENDATION**

A detailed letter or recommendation from an academic official, employment supervisor or other adult (not a family member) who knows the applicant is required. The letter must include at least two achievements and character traits describing why the applicant deserves the award. Specific situations where these qualities have been exemplified should be included. Please note the letter writers name and relationship to the applicant.

### **SECTION V – ESSAY**

Please describe in an essay of 500-1000 words, your most meaningful achievements, how they relate to your field of study and your future goals and how this award will help you achieve those goals.

### **SECITON VI – FINANCIAL INFORMATION**

Selections for the scholarship are partially based on financial needs. It is, therefore essential that you provide the following information. The information will be kept confidential and will be used solely for assessing financial need.



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**Estimated Expenses for the Coming Academic Year at First Choice School:**

Name and Address of Institution:

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Tuition & Fees        \$\_\_\_\_\_

Books & Supplies    \$\_\_\_\_\_

Living Expenses     \$\_\_\_\_\_

List any other expenses incurred for school:

\_\_\_\_\_ \$\_\_\_\_\_

\_\_\_\_\_ \$\_\_\_\_\_

\_\_\_\_\_ \$\_\_\_\_\_

On a separate sheet, list any other information related to finances that you want the judges to consider.

**SECTION VII – CERTIFICATION OF ACCURACY AND UNDERSTANDING**

I certify that the information provided on this application is correct to the best of my knowledge. I understand that I must submit, in addition to this application, a copy of my most recent high school and (if applicable) college transcript, at least two letters of recommendation and the required essay.

Applicant's Full Name: \_\_\_\_\_

Applicant's Signature: \_\_\_\_\_

Date: \_\_\_\_\_



## Application for Assistance

*\*PLEASE FILL OUT ENTIRE APPLICATION IN AS MUCH DETAIL AS POSSIBLE\*  
PLEASE PRINT OR TYPE*

**Name:**

**Phone #:**

**D.O.B.**

**SS#:**

**Address (please include your county):**

**Email (only provide if you regularly check it):**

Preferred method of contact \_\_\_ Phone \_\_\_ Email

\*If you indicate email is a preferred method, please regularly check the email account

1. How did you hear about us?

2. Do you hold a Commercial Driver's License?

Yes  # \_\_\_\_\_ No

3. Is driving a commercial vehicle your primary source of income or was it before a medical problem evolved?

Yes  No

4. Who do/did you drive for?

Name:

Phone #:

Contact Person:

Do we have your permission to contact the above to confirm your income? Yes  No



5. Describe **in detail** the medical problem(s) which has caused or led to financial difficulty and have left you unable to drive professionally again. Please list the **last date of employment**.

6. Name and number of physician(s) caring for the above described medical problem(s). If listing more than one physician, please include the physician's specialty.

Fax number for medical records for each physician listed. **Your application cannot be processed without the fax number.** To get the number, call the hospital/doctor's office and ask for medical records.

7. Do you have health insurance?      Yes                          No   

If yes: Name of insurance company \_\_\_\_\_

8. Is the medical care needed covered through your existing health insurance?

Yes                          No                          N/A   

9. Is the medical care covered through Medicare/Medicaid?

Yes                          No                          N/A



10. Are you able to pay the full cost of needed medical care?

Yes  No  N/A

If no, how much are you able to pay? \_\_\_\_\_

11. Have you applied for social security disability?

Yes  No  N/A

If yes, what is the status?

12. Have you applied for unemployment?

Yes  No  N/A

If yes, what is the status?

13. Are you able to get short-term disability?

Yes  No  N/A

14. Are you able to get long-term disability?

Yes  No  N/A

15. Is the described medical problem/condition related to a worker's compensation case?

Yes  No



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16. What is your current **monthly** take-home (i.e., net income) pay? Other household monthly income (e.g., spouse's income)?

Yours: \$ \_\_\_\_\_ Other's: \$ \_\_\_\_\_ or N/A

If you are not working, what was your income while you were working? \$ \_\_\_\_\_

17. Are you receiving assistance from other organizations (e.g. getting food stamps)?

Yes  No  N/A

If yes, please describe below:

18. **List** your monthly expenses (mortgage, car payment, utilities, etc)? Please be sure to list all of your expenses.

19. Are/were you an Owner Operator?

Yes  No

If yes, please list your monthly business expenses



20. How many people live in your household and what are their ages?

21. What type of assistance do you need? For instance, are you behind on bills or anticipate being behind? Do you need help negotiating hospital or doctor's bills?

I attest that the above information is accurate and true.

\_\_\_\_\_

Signature

\_\_\_\_\_

Date

The St. Christopher Fund has my permission to use my case (without using my name) on their website, in flyers, newsletters, brochures, and/or on air as an example of how the Fund helps drivers. **Your signature is NOT required and will have no bearing on whether or not you qualify for assistance.**

\_\_\_\_\_

Signature

\_\_\_\_\_

Date



**St. Christopher Fund Medical Release Form**

\_\_\_\_\_  
**Full Name**

\_\_\_\_\_  
**Social Security Number**

\_\_\_\_\_  
**Date of Birth**

\_\_\_\_\_  
**Telephone Number**

Covering the period(s) of health care:  
From (date) \_\_\_\_\_

To (date) \_\_\_\_\_

This information is to be disclosed to:  
St. Christopher Truckers Development & Relief Fund  
PO Box 30763 Knoxville, TN 379930  
Phone 865-202-9428 Fax 865-851-8396

Doctors/Hospital Releasing Records:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I hereby authorize use or disclosure of protected health information about me to the St. Christopher Truckers Development and Relief Fund. These records may be viewed by members of the review committee in order to determine if I qualify for assistance from the program. I understand that this authorization expires in 1 year from today. I understand that the information used or disclosed may be subject to re-disclosure by the St. Christopher Fund, and would then no longer be protected by federal privacy regulations.

I may revoke this authorization by notifying the St. Christopher Fund in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

I DO NOT WANT THE FOLLOWING INFORMATION DISCLOSED (as defined by applicable state and federal laws):  Alcohol/Drug Abuse  HIV Test Result  Mental Health/Developmental Disabilities

I understand that I have the right to refuse to sign this form and that my refusal will not result in the physician conditioning the provision of healthcare with this exception: Refusal to sign this authorization, if it is for disclosure of information created for approval of financial assistance, may result in the board declining financial assistance.

\_\_\_\_\_  
**Signature of Individual**

\_\_\_\_\_  
**Date**

*Or, if applicable:*

\_\_\_\_\_  
**Signature of Guardian or Personal Representative**

\_\_\_\_\_  
**Date**