Application for Scholarship Assistance for
Buffalo Hearing & Speech Center Language to Literacy Program

Please complete both pages of this form and return with copies of your **latest tax return documents** (e.g. Form 1040; filed in 2006 or 2007) **and your most recent pay stub** to be considered for scholarship funds. Please note completion of this form does not in any way guarantee you or your child will receive financial assistance. You will be notified as soon as possible if you are eligible for scholarship funds.

Return form to: Buffalo Hearing and Speech Center
50 East North Street
Buffalo, NY 14203

Your Name ____________________________________ Child ________________________

Relationship to Child ____________________________

Address ____

Phone Numbers____

1. The total cost for the Language to Literacy Program is as follows:
    - Supply Kit: $200 (includes binder, books, materials, incentive items, etc.)
    - Tuition $1000 (equals $50.00 per day) **or** your insurance co-pay

    What amount do you believe you can contribute? ________________

2. Are you or a responsible adult able to provide transportation for your child to and from the Language to Literacy Program three days per week? _____Yes _____No

3. Present Combined Yearly Gross Salary of Primary Parents/Guardians (before taxes):
    $______________
    (attach copy of most recent pay stub)

Parent or Guarantor #1:
Relationship to patient: ☐ self ☐ child ☐ spouse

Name: ____

Employer: ____

Insurance Coverage : ____

Major Medical Coverage :____

Annual Gross : ______________________ Amount Net : ________________

Parent or Guarantor #2:

Relationship to patient: ☐ self ☐ child ☐ spouse

Name: ____

Employer: ____

Insurance Coverage: ____

Major Medical Coverage: ____

Annual Gross: ______________________ Amount Net : _____________________

Number of Children: at home _________ outside home _______________

4. Please check the box to indicate what insurance company your child has, if any:

☐ Independent Health
☐ Community Blue
☐ Univera
☐ Fidelis
☐ Policy Number _______________________
☐ My child is not covered by insurance
☐ Medisource
☐ Medicaid
☐ ___________________+ Medicaid
☐ Other _______________________

5. Please check the box(es) to indicate any financial assistance you are currently receiving and list the amount of funds you receive per month:

☐ Medicaid: $_________
☐ Food Stamps: $_________
☐ Child Support: $_________
☐ Unemployment: $_________
☐ Other & Monthly Amounts____
☐ NYS Disability: $_________
☐ Temporary Assistance for Needy Families (TANF): $_________
☐ Alimony: $_________

6. Please list if there any other financial hardships that affect your ability to afford this program that you feel we should know about.

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7. Are you willing to commit to spending 15 – 30 minutes for 3 – 4 nights per week working with your child to maximize your child's progress?
____No. List Reason(s):
____

_____Yes. List Reason(s):
____

Additional Comments: ____

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Thank you for applying for financial assistance to the Language to Literacy Program.

☐ I certify that all my answers are correct and true to the best of my knowledge.
☐ I have enclosed a copy of my most recent tax return documents.
☐ I have enclosed a copy of my most recent pay stub.

Signature ____ Date ______________

Print Name _______________________________________

For Office Use Only – Do Not Write Below this Line

Date Application Received: ________________

Tax Return Documents Included ____________

Date Reviewed _________________________

☐ Application Approved for $_________ Scholarship

☐ Application Denied for ____

Director's Signature ______________________________ Date_____________________

CFO's Signature _________________________________ Date ____________________

Implemented March 14, 2005