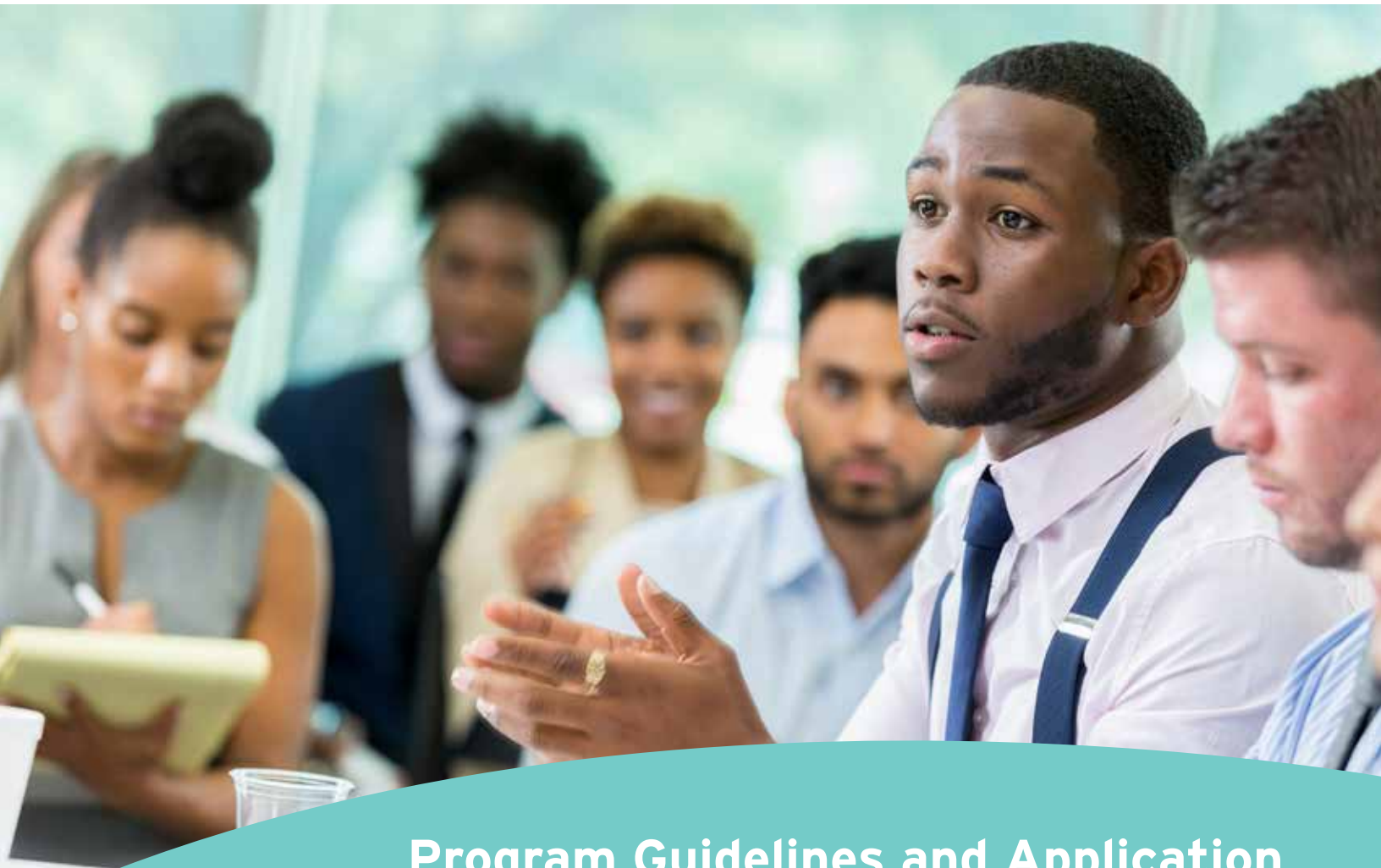




2019-2020 Carolyn Wilson Dialysis Patient Scholarship

*Exclusively for residents of
Arkansas, Louisiana or Oklahoma*



Program Guidelines and Application

The American Kidney Fund is pleased to announce the **Carolyn Wilson Dialysis Patient Scholarship Program**. This program provides support for people with end stage renal disease (ESRD) **who are residents of Arkansas, Louisiana, or Oklahoma** and wish to further their education or vocational training as part of an effort to initiate, maintain or resume employment and independent living. Guidelines are below and application materials are enclosed.

The American Kidney Fund (AKF) is the nation's leading nonprofit working on behalf of the 30 million Americans with kidney disease. AKF fulfills its mission by providing a complete spectrum of programs and services: national prevention outreach, top-rated health educational resources, and direct financial assistance enabling kidney patients to access lifesaving medical care, including dialysis and transplantation.

AKF helps 1 out of every 5 U.S. dialysis patients with treatment-related expenses. More than 87,000 patients in all 50 states and Puerto Rico received AKF grants last year. The Carolyn Wilson Dialysis Patient Scholarship is made possible by a contribution from ESRD Network 13.

Eligibility

To qualify for the Carolyn Wilson Scholarship, you must be a resident of either Arkansas, Louisiana, or Oklahoma AND have been diagnosed with ESRD (stage 5 kidney disease).

The American Kidney Fund is committed to providing scholarships to all dialysis patients who meet the following program guidelines.

- Must be a resident of Arkansas, Louisiana or Oklahoma
- Must demonstrate financial need through the expenses vs. income table (#6 on application)
- Must be a current dialysis patient or a kidney transplant recipient

While this program is for patients diagnosed with stage 5 kidney disease (ESRD), priority will be given to dialysis patients.

Qualifying Programs and Expenses

Scholarships will be provided for university, college, community college education or vocational training. Scholarship funds can only be used for tuition. Funds cannot be used for books, transportation to classes, and other needs.

Amount of Award

Scholarships of up to **\$5,000** per academic year (fall, spring, and summer semesters combined) per person will be awarded. The scholarship period lasts for one year. Funding for subsequent years will depend on availability of funds

and documentation of successful completion of the previous academic year. Applicants can receive funding for up to two years and are required to reapply to be considered for a second year of funding.

If awarded a scholarship, funds will be paid directly to the educational or vocational institution.

If awarded, recipients are required to sign a letter of acceptance, confirming school/institution enrollment.

Application Process

Applications may be photocopied or downloaded on our website at kidneyfund.org/scholarship. To apply for the Carolyn Wilson Scholarship, you must submit the following by June 30, 2019:

- **A completed application form**
- **A Statement of Purpose:** a 2-3 page essay describing the effect of kidney disease on their lives; and how the proposed education or training program will enhance their ability to initiate, maintain or resume employment and independent living.
- **A reference letter** from a nephrology professional (doctor, nurse, social worker, dietitian) caring for the applicant with an assessment of the applicant's ability to maintain compliance with their treatment regimen, while pursuing the educational or vocational program.

Only complete applications will be accepted.

Complete applications can be either sent by mail or by email to:

American Kidney Fund
Attn: Professional Education
11921 Rockville Pike, Ste. 300
Rockville, MD 20852

or

education@kidneyfund.org

NOTE: The required reference letter and Statement of Purpose must be included in the email along with the application.

Applications must be postmarked or emailed by **June 30, 2019**. Late or incomplete applications will not be considered. An application is not a guarantee of an award.

Reporting Requirements

In order to maintain this scholarship, applicants must be able to demonstrate academic success. Therefore, AKF requires scholarship recipients to deliver a progress report (1-2 pages) at the completion of the academic term for which funding was received. Recipients must also provide a transcript within 60 days of term completion to show achievement of a minimum grade point average (GPA) of 2.5. If the recipient is in vocational training, he/she must demonstrate continued advancement or completion of vocational course work.

Carolyn Wilson Dialysis Patient Scholarship Program

Application Checklist

- Completed application form.
 - 2018 federal income tax return, if applicable. **Please black-out or remove social security number.**
 - Parents' 2018 federal income tax return, if applicable. **Please black-out or remove social security number.**
 - Copy of tuition bill from enrolled program.
 - Reference letter from nephrology professional (no more than 2 typed pages).
 - Statement of Purpose essay about how kidney disease has affected your life; and how the proposed education or vocation training will help you as part of an effort to initiate, maintain or resume employment and independent living (no more than 2-3 pages typed).
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Mail or email your complete application packet to:

**American Kidney Fund
Attn: Professional Education
11921 Rockville Pike, Suite 300
Rockville, MD 20852**

or

education@kidneyfund.org

NOTE: The required reference letter and Statement of Purpose must be included in the email along with the application.

Applications must be received by **June 30, 2019**. You will be notified of scholarship selection no later than **July 31, 2019**.

For any questions, please email education@kidneyfund.org
or call 800-638-8299, ext. 7052



Carolyn Wilson Dialysis Patient Scholarship Program

1. Personal Information

Name _____ Date of Birth _____ (DD/MM/YYYY)

Address (No. & Street) _____

City _____ State _____ Zip _____

Telephone (____) _____ Email Address _____

How Do You Describe Yourself? (Check all that apply)

- African American
- Asian
- Caucasian
- Hispanic/Latino
- American Indian/
Alaska Native
- Native Hawaiian/Pacific
Islander
- Other (please specify)

How Did You Hear About This Scholarship? (Please specify) _____

2. Emergency Contact Information

Name of Emergency Contact Person _____

Relationship to Applicant _____

Phone (____) _____

3. Medical Information

Date of Kidney Disease Diagnosis _____

Current Treatment Modality

- Hemodialysis In Center At Home
- Peritoneal Dialysis
- Transplant Recipient

Current Treatment Facility Name _____

Address (No. & Street) _____

City _____ State _____ Zip _____

Telephone (____) _____

Name of Nephrology Professional Providing Reference _____

- Physician Social Worker Nurse Dietitian Other (please specify) _____

4. Nephrology Professional Reference

Please attach a statement (of no more than two typed pages) from a nephrology professional caring for the applicant with an assessment of the patient's ability to maintain compliance with their treatment regimen while pursuing the educational or vocational program.

5. Education (if applying for academic scholarship)

What Is The Highest Level Of Schooling That You Have Completed?

- | | |
|--|---|
| <input type="checkbox"/> High School | <input type="checkbox"/> College, Completed Degree |
| <input type="checkbox"/> Currently A Senior In High School | <input type="checkbox"/> I Am Currently Attending College |
| <input type="checkbox"/> College, Did Not Complete Degree | What Year? _____ |

High School or College Attended or Attending:

Name of School or College _____

Address (No. & Street) _____

City _____ State _____ Zip _____

Telephone (_____) _____

Institution to which Scholarship Will Be Applied:

Name of Institution _____

Address (No. & Street) _____

City _____ State _____ Zip _____

Telephone (_____) _____

Major Field of Study _____ Career Objective _____

6. Vocational Information (if applying for vocational training)

Current Job Title and Employer _____

Institution to which Scholarship Will Be Applied:

Name of Institution _____

Address (No. & Street) _____

City _____ State _____ Zip _____

Telephone (_____) _____

Type of Training _____

Career Objective _____

7. Patient Financial Information

Patient's monthly expenses vs. income will be evaluated to determine financial need.

Assets

Checking Acct. \$ _____

Savings Acct. \$ _____

Home (Assessed Value) \$ _____

Stocks & Bonds \$ _____

Auto (List year/make) _____

_____ \$ _____

College savings (529 Plans & ESAs) \$ _____

Total Assets \$ _____

Monthly Income

Take Home Pay \$ _____

Parents' Take Home Pay (if applicable) \$ _____

Other Scholarships \$ _____

Addl. Household Income \$ _____

Social Security Aid to Children \$ _____

Child Support \$ _____

Welfare Benefits \$ _____

Retirement Income \$ _____

Veteran's Benefits \$ _____

Social Security benefit \$ _____

Other (specify*) \$ _____

Total Monthly Income \$ _____

Monthly Expenses (Household)

Rent Mortgage \$ _____

Food \$ _____

Phone \$ _____

Gas (home) \$ _____

Water \$ _____

Electricity \$ _____

Water \$ _____

Transportation \$ _____

Auto Payment(s) \$ _____

Taxi Fee/Gasoline \$ _____

Medical Expenses

Patient's Medication \$ _____

Family Medication \$ _____

Other \$ _____

Health Insurance \$ _____

Life Insurance \$ _____

Auto Insurance \$ _____

Credit Accounts \$ _____

Loans Total (specify*) \$ _____

Misc. (specify*) \$ _____

Total Monthly Expenses \$ _____

*Use this area to specify where needed.

8. Financial Information/Parents' Financial Information

Please attach a copy of your federal tax return. If applicant is under 18 years of age or living with and/or supported by parents, please attach parents' 2018 federal tax return. Black-out or remove social security numbers. Please indicate if you are unemployed.

9. Scholarship Request

Please provide a copy of the tuition bill for the program for which you are requesting financial assistance.

If a current bill is not available, please estimate the tuition amount and provide a hardcopy as soon as possible.

Tuition \$ _____

10. Statement of Purpose

Please attach a 2-3 page essay describing the effect of kidney disease on your life; and how the proposed education or training program will enhance your ability to initiate, maintain or resume employment and independent living.

11. Verification and Release

- I attest that the information I have provided is complete and accurate and I agree that the American Kidney Fund (AKF) may verify this information.
- I agree that AKF may disclose information contained in this application to my nephrology caregivers and/or any vendors who help fulfill my request.
- I give my written consent for an AKF agent/representative to contact me via phone/email for the purposes of completing this scholarship request and/or informing me of AKF related events and initiatives.
- If the American Kidney Fund awards a scholarship to me, I hereby authorize AKF, on a royalty-free basis, to include my life-story as part of its publicity and fund-raising initiatives.
- I have read the guidelines and understand I must meet progress and reapplication guidelines to receive a second year of funding.

Applicant's Signature _____ Date _____

Parent's Signature _____ Date _____
(if applicable)