House of Everyday Learning
3001 11th St. So., Fargo, ND 58103
Ph: 701.356.0062

Scholarship Form

Groups/Camps

Today's date_____ Form completed by: _____

If provided financial assistance, we ask that you please consider making a tax-deductible donation.

PROGRAM AREAS

Current Program Areas of Interest (check all that apply)

Approximately 50% of programming costs are covered by grants and donations
Your portion of the program cost is listed below.

____ Let's Grow OuTside 1 = $385.00
____ Let's Grow OuTside 2 = $385.00
____ Social Connections 1 = $250.00
____ Social Connections 2 = $250.00
____ Coping after COVID = $250.00
____ Sibling Support Program 1 = $250.00
____ Sibling Support Program 2 = $250.00

****Financial assistance is not for long term therapy and will be reviewed for a short-term basis only**

Amount of financial assistance requested: _____

Is this the first time receiving services from the House of Everyday Learning? ____Yes ____No

If no, what services has this client received before and approximate dates?

_____

SECTION 1

Name of Client _____
Last First Middle

Residence of Client _____
Street Address City State Zip

Phone _____ Cell _____

Client Age: _____ Birthdate: _____ Gender: _____

Has client been evaluated for services before? ____Yes ____No
If yes, give therapist/location where evaluation took place:_____

Was therapy recommended? ____Yes ____No
Why? _____

Has previous treatment been received? ____Yes ____No

If yes, give name of service organization and approximate dates of therapy: _____

How did you find out about the House of Everyday Learning? _____

SECTION 2

*All information collected on this form is strictly confidential and will only be viewed by Board Members on the Scholarship committee.

Number of dependent children: _____ Ages: _____

An accurate completed form will assist in determining if you are eligible for a scholarship. The worksheet below will help ensure that you include all income sources and all regular monthly expenses. Please enter the information below to the best of your knowledge. If an area does not apply, please write N/A.

Prior month check stub(s) to be included with application. Based on information submitted, additional information/ documentation may be required.

Income/Cash Flow Analysis (ANNUAL)			Projected Debt-to-income Analysis (MONTHLY)		
Income Type:	Current Year	Comments		Monthly Expenses	Comments
Annual Gross Income Salary, Wages, etc.			Home Mortgage/Rent		
Other Income not indicated on tax return			Real Estate Tax or Fees		
Gross Annual Cash Flow (Typically your tax return adjusted/gross income			Home Equity Line of Credit payment		
Less: Federal and State			Car Payment #1		
			Car Payment #2		
			Boat/Camper Payment		
			Monthly Daycare Payment		
			School Payment/Tuition		
			Utilities/Heat/Water/ Garbage/Electricity/ Phone/Cable		
			Insurances: Car, Life; Medical		
			Monthly Credit Card payments		
			Monthly Essentials: i.e. Groceries, Clothing, Gas for Vehicle, Medications/Pharmacy		
Adjusted Gross Income (after taxes/take home)			Other Debt not stated above		
Gross Monthly Cash Flow			**Total monthly Debt**		

_____Prior month check stub(s) attached.

Please answer these questions if applicable:

☐ Yes ☐ No Do you participate in a Medical Flex Plan? Yearly Medical or HSA contributions _____
☐ Yes ☐ No Do you participate in a Childcare Flex Plan? Flex money available as of today_____
☐ Yes ☐ No Do you participate in a Health Savings Account (HSA)?

Applicant Signature _____ Date _____

Co-Applicant Signature _____ Date _____

SECTION 3 - CONDITIONS OF APPLICATION – Caregiver / Guardian / Client – READ CAREFULLY

Application is hereby made for the above-named client at the House of Everyday Learning. Acceptance of this client for engagement in groups/camps, and with the consents, in this application stated.

I hereby agree as follows:

1) To deliver the client to the House of Everyday Learning when requested to do so.
2) To waive and relinquish any and all claims or liabilities against the House of Everyday Learning, their associated, affiliated or parent bodies.

ALTERING THIS APPLICATION IN ANY WAY WILL RESULT IN DISAPPROVAL

Caregiver / Guardian / Self 1 Signature _____

Printed Name _____

Relationship ☐ Caregiver ☐ Guardian ☐ Self ☐ Other_____

Caregiver / Guardian / Self 2 Signature _____

Printed Name _____

Relationship ☐ Caregiver ☐ Guardian ☐ Self ☐ Other_____

SECTION 4

THERAPISTS RECOMMENDATION / COMMENTS:

Signature of Therapist_____ Date _____

SECTION 5 - ACTION OF BOARD OF DIRECTORS

☐ Approved Date _____ ☐ Disapproved Date_____

Details:	***Details:***

Mail completed form to:
House of Everyday Learning
3001 11th St. So.
Fargo, ND 58103

Signature_____
House of Everyday Learning Representative

The House of Everyday Learning is committed to equal opportunity for all persons without regard to sex, age, race, color, religion, creed, national origin, marital status, disability or sexual orientation.