BENEFITING FORMER PATIENTS OF

Application Packet

DEADLINE FOR APPLICATION – March 8, 2024

Criteria: *Scholarships awarded to current or former patients of Scottish Rite for Children. Awards are made to students who will be attending an accredited two-year college, four-year university or technical training school in 2024.*

Legacy Scholarship Program
Application Instructions

The Legacy Scholarship Program awards scholarships to students who are current or former patients of Scottish Rite for Children. Selection is based on the student's financial need, academic record and approach to challenges.

Application Requirements

Applicants must:

1. Be a current or former patient of Scottish Rite for Children.
2. Plan to attend an accredited two-year college, four-year university or technical training school in the year of scholarship award.

Instructions for filling out the Application

1. If using a PC, open the PDF application form and SAVE it to your computer so you will have continued access.
2. If using a Macintosh, you must download Adobe Acrobat Reader or Adobe Acrobat Pro or above in order to open the PDF application and fill it out properly. Without one of these you will be able to type your information on the form, but the information will not save and your application will be blank when emailed.
3. Each time you add typed information to the application, **save it again**.
4. The complete application packet includes:
   - **Completed application form with 3 essay responses and signed Authorization to Disclose Health Information.** There are extra pages at the end of the application to type in your responses to the essay questions. Be complete and informative in all answers including your essays.
   - **Completed academic and non-academic reference form or letter**.
   - **Transcript through the fall of 2023.**
5. Submit the application.

   Incomplete applications will not be considered.

Instructions for Electronic Submission

1. Once you are ready to submit your application packet, save the completed application and attach it to an email addressed to legacy.scholarship@tsrh.org.
2. Scan and attach references and transcript and send with the application.

   Note: Once your application is received you will receive an email indicating it has been recieved.

Mailing Instructions

1. If you are unable to complete by computer, print the document and complete by printing in ink.
2. Entire application packet should be returned to the address below.

Deadline for Application

Applications, including transcript, and reference recommendations, must be mailed or delivered by March 8, 2024 in order to be considered on time. Applications must be postmarked by March 8, 2024 if mailed. The complete application may also be delivered to the Legacy Scholarship Program at the following address by March 8, 2024.

Legacy Scholarship Program
Ashley Givens, President
2222 Welborn St.
Dallas, Texas 75219

Email address: legacy.scholarship@tsrh.org

Selection Process

The selection committee of the Legacy Scholarship Program will screen all initial applications. Finalists will be invited for a personal interview. The number of scholarships awarded will be based on the available funds. The committee will make recommendations to the Legacy Scholarship Program Board. All applicants will receive a letter regarding the outcome of their application.

Recipient Responsibilities

Once the student has agreed to accept a scholarship, the student must keep the Legacy Scholarship Program informed of any address or school changes and respond to all correspondence. Scholarship monies will be sent directly to the chosen school. Failure to complete any of these requirements may result in a loss of the scholarship or a delay in processing scholarship payments to schools.

For further information or questions, please contact the Legacy Scholarship Program at 214-559-7816 or legacy.scholarship@tsrh.org. You may also check our website for information: www.legacyscholarshipprogram.org.

Legacy Scholarship Application

Deadline for application – March 8, 2024

PERSONAL INFORMATION:

NAME: ____
First Middle Last

PERMANENT ADDRESS: ____
Street (P. O. Box) City/State Zip

CURRENT ADDRESS: ____
Street (P. O. Box) City/State Zip

CELL PHONE: ____________________ HOME PHONE: ____________________

AGE: __________ DATE OF BIRTH: ______________________________

E-MAIL ADDRESS: ____

SCHOOL STUDENT ID# IF ALREADY ENROLLED IN COLLEGE: ____________________

FAMILY INFORMATION:

With whom do you live? ____
Please specify

PARENT INFORMATION:

NAME: ______________________________ CELL PHONE: ____________________

HOME ADDRESS: ____
Street Address City State Zip

EMAIL ADDRESS: ____

HOME PHONE: ____________________ WORK PHONE: ____________________

EMPLOYED BY: ____________________ OCCUPATION: ____________________

PARENT INFORMATION:

NAME: ______________________________ CELL PHONE: ____________________

HOME ADDRESS: ____
Street Address City State Zip

EMAIL ADDRESS: ____

HOME PHONE: ____________________ WORK PHONE: ____________________

EMPLOYED BY: ____________________ OCCUPATION: ____________________

LIST OF NAMES AND AGES OF OTHER MEMBERS IN YOUR FAMILY SUPPORTED BY YOUR PARENT(S). PLEASE STATE IF ANY ARE IN COLLEGE.

Sibling(s) Name	Age	In college?		Sibling(s) Name	Age	In college?	
______________	____	Yes	No	______________	____	Yes	No
______________	____	Yes	No	______________	____	Yes	No
______________	____	Yes	No	______________	____	Yes	No

MEDICAL HISTORY:

MEDICAL DIAGNOSIS:

TREATMENT RECEIVED AT SCOTTISH RITE FOR CHILDREN:

SCOTTISH RITE PHYSICIAN AND/OR HOSPITAL STAFF MEMBERS WHO TREATED YOU:

WHAT RELATIONSHIPS WERE MEANINGFUL TO YOU AT THE HOSPITAL AND WHY?

IN WHAT WAY DOES YOUR MEDICAL HISTORY CONTINUE TO IMPACT YOUR LIFE?

ACADEMIC RECORD:

HIGH SCHOOL INFORMATION

HIGH SCHOOL: ____ GRADUATION DATE: ___________________________
(month and year if date is not available)

GRADE AVERAGE: ________ RANK IN CLASS (if ranked): ________ # OF STUDENTS IN GRADUATING CLASS: _________

***PROVIDE NUMBER IN GRADUATING CLASS EVEN IF NOT RANKED.**

PLEASE INCLUDE A COPY OF YOUR TRANSCRIPT INCLUDING THE FALL SEMESTER OF 2023.

If attending a Texas Public High School, have you passed the required STAAR End-of-course (EOC) assessments (or your state's equivalent testing for graduation)? YES NO Not Applicable

ACT SCORES:

English	Math	Reading	Science	Writing

SAT SCORES:

Reading / Writing / Language	Math	Total

COLLEGE COURSEWORK:

HAVE YOU RECEIVED COLLEGE CREDIT (Dual Credit) FOR ANY OF YOUR HIGH SCHOOL CLASSES? YES NO

IF YES, NUMBER OF COLLEGE CREDITS RECEIVED WHILE ATTENDING HIGH SCHOOL: ___________

and GPA: __________

IF YOU GRADUATED FROM HIGH SCHOOL PRIOR TO MAY 2024? ARE YOU CURRENTLY ATTENDING SCHOOL?

YES NO

IF ANSWER IS YES – WHAT SCHOOL ARE YOU CURRENTLY ATTENDING? ______________________

OF HOURS COMPLETED: ______________ CURRENT # OF HOURS ENROLLED: ____________

CUMULATIVE GPA: __________

INCLUDE A COPY OF YOUR COLLEGE TRANSCRIPT INCLUDING THE FALL SEMESTER OF 2023.

COLLEGE APPLICATION:

Please list the colleges or universities to which you have applied:

Name of college or university	Application Status		Scholarship/Grant awarded		Amount
	Accepted	Pending	Yes	No	
	Accepted	Pending	Yes	No	
	Accepted	Pending	Yes	No	
	Accepted	Pending	Yes	No	

Please indicate the major(s) or fields of study you are interested in pursuing:

Major:	Fields of study:

FINANCIAL NEED:

IF FINANCIAL INFORMATION IS NOT COMPLETE, YOUR APPLICATION CANNOT BE CONSIDERED.

NOTES for **Who is Considered a Parent** when determining parents' adjusted gross income above:

If your parents are both living and married to each other, answer the questions about them.

If your parent is single or widowed, answer the questions about that parent. If your parent is remarried as of today, answer the questions about that parent **and** the person to whom your parent is married (your step-parent).

If your parents are divorced or separated, answer the questions about the parent you lived with during the past 12 months. (If you did not live with one parent more than the other, give answers about the parent who provided more financial support during the past 12 months or during the most recent year that you actually received support from that parent.) If this parent is remarried as of today, answer the questions on this form about that parent **and** the person to whom your parent is married (your step-parent).

EXPLAIN ANY CIRCUMSTANCES THAT AFFECT YOUR FAMILY'S ABILITITY TO HELP FINANCE YOUR COLLEGE EDUCATION.

DO BOTH PARENTS CONTRIBUTE FINANCIALLY TO YOUR SUPPORT NOW AND WILL THEY CONTINUE TO DO SO WHILE YOU ARE IN SCHOOL?

Yes No Please explain, if necessary:

NOTE: The following financial questions are adapted from the Free Application for Federal Student Aid (FAFSA) application. **If you have not already completed the FAFSA form, we encourage you to do so. FAFSA forms must be submitted by 11:59 p.m. CT on June 30, 2024. Any corrections or updates must be submitted by 11:59 p.m. CT on Sept. 14, 2024. Completing the FAFSA application and other scholarship applications shows us your initiative to obtain support from more than one source.** If you or your parents have not yet filed a current tax return, use the prior year with notations of any major changes in income.

A. What type of tax return did your parents file most recently? (If you provide your own primary financial support, please indicate and answer according to your own income and income tax.)

IRS 1040 IRS 1040A or 1040EZ Other: ______________________

B. What was your or your parents adjusted gross income from IRS form? $ ____________ Year: __________

THIS INFORMATION MUST BE COMPLETED FOR CONSIDERATION.

C. Please explain any significant income changes.

<u>OTHER SCHOLARSHIPS, GRANTS AND LOANS:</u> We are interested in your initiative to apply for scholarships and financial aid. Please list below all other scholarships (including programs such as SCHOOL FINANCIAL AID OFFICE) **to which you have applied.** Add additional sheet if needed. If currently attending college or technical school, indicate assistance received this year. **List all applications!**

SCHOLARSHIPS	APPLIED FOR	AWARDED			AMOUNT AWARDED
	______________________	Yes	No	Pending	____________
	______________________	Yes	No	Pending	____________
	______________________	Yes	No	Pending	____________
	______________________	Yes	No	Pending	____________
	______________________	Yes	No	Pending	____________
LOANS	______________________	Yes	No	Pending	____________
WORK/STUDY	______________________	Yes	No	Pending	____________

WE STRONGLY ENCOURAGE YOU TO APPLY FOR FAFSA (Free Application for Federal Student Aid) AND OTHER SCHOLARSHIPS BEFORE YOU MAIL IN YOUR LEGACY SCHOLARSHIP APPLICATION.

HAVE YOU APPLIED FOR FAFSA? YES NO DATE FAFSA APPLICATION SUBMITTED: ____________
FAFSA forms must be submitted by 11:59 p.m. CT on June 30, 2024. Any corrections or updates must be submitted by 11:59 p.m. CT on Sept. 14, 2024.

Please explain how you plan to cover your educational expenses, including housing and any special needs you may have. (It is not realistic to indicate you plan to cover your expenses with scholarships and loans if you have not applied for scholarships and loans.)

<u>COMMUNITY SERVICE / WORK INFORMATION</u>: We encourage you to attach your resume if available.

COMMUNITY SERVICE: Please describe any volunteer or community service in which you have participated.

ACTIVITY	DATES Start	DATES End	Total # of Hours

LEADERSHIP ROLES

Please list any extra-curricular activities, honors, positions of leadership or roles of responsibility which you have held.

ACTIVITY	POSITIONS/HONORS

WORK HISTORY

PLACE OF EMPLOYMENT	DATES OF EMP Start	End	JOB DUTIES	HOURS/ WEEK

HOW DID YOU FIND OUT ABOUT THE LEGACY SCHOLARSHIP PROGRAM

Online In clinic Through school Other: ____________________

ESSAY QUESTIONS:

PLEASE USE THE EXTRA PAGES AT THE END OF THIS DOCUMENT TO COMPLETE YOUR 3 ESSAY QUESTIONS.

1. Please describe your goals for your education and future vocation and what led you to those goals.
2. What personal strengths and skills do you possess that will allow you to be successful next year in school?
3. Describe your greatest challenge and how you have approached it.

LETTERS OF REFERENCE

Attached are TWO reference forms. Give ONE to your ACADEMIC reference and ONE to your NON-ACADEMIC reference. Please ask these people to return their Letter of Reference to YOU, to be returned with YOUR APPLICATION.

A. An Academic Reference, such as a High School Counselor or Teacher of a major subject.
B. A Non-Academic Reference outside of your family.

DISCLOSURE OF HEALTH INFORMATION

Complete and Sign AUTHORIZATION TO DISCLOSE HEALTH INFORMATION. Include this with your application.

A. If you are over 18, you may sign.
B. If you are not yet 18, have your parent or legal guardian sign.

PLEASE CHECK TO BE SURE YOUR APPLICATION IS COMPLETE.
AN INCOMPLETE APPLICATION CANNOT BE CONSIDERED.

The completed application must be postmarked or delivered no later than **MARCH 8, 2024** and should be mailed to:

LEGACY SCHOLARSHIP PROGRAM
ASHLEY GIVENS
2222 WELBORN ST.
DALLAS, TEXAS 75219

YOUR APPLICATION PACKET MUST CONTAIN ALL OF THE FOLLOWING MATERIALS BEFORE IT CAN BE CONSIDERED FOR AN AWARD.

COMPLETED APPLICATION

DID YOU ANSWER REQUIRED **QUESTIONS #1 AND #2 UNDER FINANCIAL NEED**? You may attach a copy of the most recent tax return for you, your parents or guardians (Tax return not required).

COMPLETED ANSWERS TO **ALL THREE ESSAY QUESTIONS**

COPY OF YOUR **HIGH SCHOOL TRANSCRIPT INCLUDING FALL 2023** - OR -

IF YOU ARE **ALREADY ATTENDING COLLEGE OR TECHNICAL SCHOOL**, SEND A COPY

OF YOUR COLLEGE TRANSCRIPT INCLUDING FALL 2023.

LETTER OF REFERENCE FROM AN ACADEMIC REFERENCE

LETTER OF REFERENCE FROM A NON-ACADEMIC REFERENCE

AUTHORIZATION TO **DISCLOSE HEALTH NFORMATION** – ADULT OR MINOR – RETURN

WITH APPLICATION – DO NOT MAIL TO MEDICAL RECORDS DEPARTMENT.

If you have any questions, please call the Legacy Scholarship Program at 214-559-7816.

Legacy Scholarship Program
Essay Question 1
Page 1

Please describe your goals for your education and future vocation and what led you to those goals. (Minimum 300 word count)

If more space is needed, expand to extra pages and label with question # and page #.

Legacy Scholarship Program
Essay Question 2
Page 1

What personal strengths and skills do you possess that will allow you to be successful next year in school? (Minimum 300 word count)

If more space is needed, expand to extra pages and label with question # and page #.

Legacy Scholarship Program
Essay Question 3
Page 1

Describe your greatest challenge and how you have approached it. (Minimum 300 word count)

If more space is needed, expand to extra pages and label with question # and page #.

Legacy Scholarship Program
Extra Page

Please enter the page number of the question you are answering and a question number in the space provided.

Page number: ______ Question number: ______

Legacy Scholarship Program
Extra Page

Please enter the page number of the question you are answering and a question number in the space provided.

Page number: ______ Question number: ______

Legacy Scholarship Program
Extra Page

Please enter the page number of the question you are answering and a question number in the space provided.

Page number: ______ Question number: ______

Legacy Scholarship Program
Academic Reference Form

Applicant's Name: ______________________________________

The Legacy Scholarship Program benefiting the patients of Scottish Rite for Children would appreciate your candid evaluation of the above listed applicant. We are interested in what you feel is pertinent information about this candidate's academic and personal qualifications for this scholarship. ***Please feel free to attach an additional page if space provided is not sufficient.***

Recommender's Name: ______________________________________ Title: ______________________________________

Relationship to Student: ____

Primary Phone Number: ________________________ E-mail: ____

1. How long have you known this student and in what context?

2. What are the first words that come to mind to describe this student?

3. Please use the space provided or attach an additional sheet for comments related to this applicant's strengths and weaknesses as related to future academic and personal achievement.

We are asking the student to return your Reference Form along with the rest of their application. If you prefer to keep your answers confidential, please place all pages in a sealed envelope, and sign along the envelope seal and return envelope to the student.

Signature: ____ Date ____________________________

Legacy Scholarship Program
Non-Academic Reference Form

Applicant's Name: ___________________________

The Legacy Scholarship Program benefiting the patients of Scottish Rite for Children would appreciate your candid evaluation of the above listed applicant. We are interested in what you feel is pertinent information about this candidate's academic and personal qualifications for this scholarship. ***Please feel free to attach an additional page if space provided is not sufficient.***

Recommender's Name: _____________________________________ Title: _____________________________________

Relationship to Student: ____

Primary Phone Number: ________________________ E-mail: ____

4. How long have you known this student and in what context?

5. What are the first words that come to mind to describe this student?

6. Please use the space provided or attach an additional sheet for comments related to this applicant's strengths and weaknesses as related to future academic and personal achievement.

We are asking the student to return your Reference Form along with the rest of their application. If you prefer to keep your answers confidential, please place all pages in a sealed envelope, and sign along the envelope seal and return envelope to the student.

Signature: ____ Date ___________________________

SCOTTISH RITE FOR CHILDREN

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

MRN# (staff only):

PATIENT NAME: **DOB:** **PHONE NUMBER:**

2222 Welborn St., Dallas, TX 75219 Ph: 214-559-7455 Fax: 214-559-7422	5700 Dallas Pkwy., Frisco, TX 75034 Ph: 469-857-2075 Fax: 469-857-2076	3800 Gaylord Pkwy., Ste. 850 Frisco, TX 75034 Ph: 469-857-2075 Fax: 469-857-2076

I hereby authorize **SCOTTISH RITE FOR CHILDREN (SRC)** to disclose treatment/medical information about the patient listed above to:

PERSON / FACILITY NAME:

____

STREET ADDRESS:______________________________**CITY:**__________________**STATE:**______**ZIP:**________

PHONE NUMBER:______________________________ **FAX NUMBER:**______________________________

CHECK TYPE OF INFORMATION AUTHORIZED TO BE DISCLOSED

NOTE--The appropriate box below must be checked to avoid delay of request. We will only disclose records specifically requested.

METHOD OF DELIVERY: ❑ Pick-up ❑ Mail ❑ Fax (Healthcare Organizations Only) ❑ MyChart ❑ Verbal Communication
❑ Email to: ______________________ ❑ Encrypted ❑ Unencrypted

(Information will be sent by encrypted unless I specify otherwise. By requesting unencrypted email, I acknowledge that there is some risk that health information could be accessed by a third party.)

ELECTRONIC MEDIA: ❑CD ❑USB/Flash Drive (flat rate) ❑ **PAPER COPY** (rate dependent on # of pages)

DATE(S) OF SERVICE :______________________**through**______________________

❑ Summary Abstract (Clinic Progress Note, H&P, Operative Note, Lab, Consult, Path, Radiology, Discharge Summary, Diagnoses/Procedure List)	❑ History & Physical	❑ Complete Medical Record
❑ Facesheet – Includes Demographics	❑ Discharge Summary	❑ Billing Record
❑ Coding Summary (Diagnoses/Procedures) and Facesheet	❑ OP/Procedure Report	❑ Peer Support (Parent Name/Phone #)
❑ Progress Notes (Clinic, Inpatient or Outpatient)	❑ Lab/Path Report	______________________
❑ Center for Dyslexia Evaluation/Assessment Reports	❑ Radiology Report	❑ Form/Letter/Other:
❑ Care and Treatment – VERBAL COMMUNICATION ONLY	❑ Radiology Image - CD	
	❑ Implant Records	______________________

FOR THE PURPOSE OF: ❑Personal Records ❑School ❑Military ❑Legal ❑ SSI/Disability ❑Other ______________________
❑ **At the request of the individual** ❑Continuity of Care; *if applicable*–Upcoming Appointment Date: ______________________

YOUR INITIAL IS REQUIRED FOR THE FOLLOWNG SENSITIVE INFORMATION REQUESTS:

❑ Genetic Info (including Genetic Test Results) **Initial**________	❑ Drug, Alcohol, or Substance Abuse Records **Initial**________
❑ Mental Health (NOT Psychotherapy Notes) **Initial**________	❑ AIDS/HIV Test Results and Treatment **Initial**________

I understand that:

- ✓ This authorization will remain in effect for 1 year from the date signed. I further understand that I may revoke this authorization at any time by notifying our main campus **Health Information Management (HIM) Department in writing at 2222 Welborn Street, Dallas, Texas 75219.**
- ✓ Any Protected Health Information (PHI) released before a revocation or cancellation request – this has been released in good faith and is now in the records of a healthcare entity or provider as previously authorized.
- ✓ PHI used or disclosed pursuant to this form may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law; and information received by SRC from another healthcare provider is subject to re-disclosure according to Chap 159, TX OCC 159.005(e) & HIPAA.
- ✓ SRC is not responsible for any misuse or disclosure made by a third party to whom I have authorized release of the PHI.
- ✓ I have the right to request or inspect or copy my PHI to be used or disclosed, as provided in CFR 164.524. I also understand that under HIPAA Privacy my access to PHI may be restricted if appropriate for my care and treatment. If I have questions about disclosures of my PHI, I can contact HIM Dept. at SRC.
- ✓ I can refuse to complete this authorization and if I do complete - I understand I do not have to provide a purpose for request of my PHI.
- ✓ There may be nominal charges for copying and sending these records. This will be discussed at the time I sign or turn in this request.
- ✓ Authorizing the disclosure of PHI is voluntary and that my (my child's) healthcare treatment/eligibility for benefits will not be affected if I do not sign form.
- ✓ The information in my (my child's) health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, alcohol, or drug abuse, and/or social and family related matters. Psychotherapy notes recorded by a mental health professional documenting or analyzing conversation during a counseling session are maintained separately. Such information is subject to special protections pursuant to state and federal laws and regulations.

❑ **ID Type (Staff Only):**______________________
❑ **Request Fulfilled:** Date____________ Initials______

______________________ ______________________
Signature of Patient or Personal Representative **Date**

______________________ ______________________
Print Name of Patient or Personal Representative **Relationship of Personal Representative's Authority**

S 159 Rev 5/2022, 6/2018