



CAHH Use Only:

Date: _____ Amount Approved: _____

Approved by: _____

**Scholarship Application
for Nursing and Health Occupations students who have had cancer or have had an immediate* family member afflicted with cancer that has caused a financial hardship**

PLEASE PRINT

Date _____
Name (First, Middle, Last) _____
Address _____
City, State, Zip _____
Phone _____ Email _____
Date of Birth _____ Gender _____
Ethnicity _____ Amount Requested _____ Cost of Tuition _____

Medical Information

Who has been affected by Cancer? _____ When: _____
Relationship to Student: _____
Type of Cancer _____ Stage _____

Explanation of Need

This has created the following hardship category:

- Child Care Tuition Assistance Rent/Utilities Healthcare Costs Transportation

Include a detailed explanation of the circumstances which require you to request financial assistance.

Scholarship will be used for _____

Timeframe _____

I certify with my signature that and attest to the fact that I am in need of financial assistance, and that I have had cancer, or a member of my immediate* family has been afflicted with cancer which has caused a financial hardship.

Student Signature

Date

*Immediate family is limited to the spouse, parents, stepparents, foster parents, father-in-law, mother-in-law, children, stepchildren, foster children, sons-in-law, daughters-in-law, grandparents, grandchildren, brothers, sisters, brothers-in-law, sisters-in-law, aunts, uncles, nieces, nephews, and first cousins.

Education Institution Admissions

My signature below attests to the fact that the above student is in financial need and has a gap between what Financial Aid can provide, and what the student needs for tuition.

Signature

Date

CAHH Approval

Amount of Scholarship Granted: \$_____

Reason if denied:_____

Signature

Date

Please submit application and attachments to:
Cancer Alliance of Help & Hope, Inc., P.O. Box 3292, Palm Beach, FL 33480
Phone: 561-748-7227 Fax: 561-748-7293 Email: canceralliance@cahh.org