Financial Assistance Form

Name __________________________________________

Program Fee
The fee for the six-day Health Care Careers Exploration Camp program is $700 and includes program and activity fees, and room and board expenses.

Payment Options:
Payment will be paid by (Please check all that apply):
☐ I am interested in a scholarship. (Please fill out the information below.)
☐ I will seek private or public agency support. (Please fill out the information on the bottom of the page.)
☐ I will seek financial assistance from Vocational Rehabilitation. (Please fill out the information on the next page.)

Scholarship Information (Must be submitted by April 1, 2016)
1. A limited number of scholarships are available. All students who wish to be considered for a scholarship must submit a copy of their parents' or guardians’ 2015 tax form. The tax form is required before any scholarship assistance can be considered or granted.

2. If you have not already submitted your most recent high school transcript (showing grades since 9th grade), and unaided audiogram, please include one with this scholarship application.

3. Briefly state why you are applying for a scholarship and how much financial assistance you will require. You may continue on a second sheet of paper if you need more room to write.
(Please print clearly)
_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________
☐ How much would you or your family be able to contribute to the cost of attending the program? ______________

Private or Public Agency Support Amount to be paid $____________________________________
☐ School ☐ Community Civic Groups (i.e., Lion’s Club, etc.) ☐ Other____________________________
(If multiple agencies are paying, please provide additional contact information on a separate paper.)

Name of supporting organization, agency, charity or fraternal group ______________________________________

Name of contact person __________________________________________________________________________

Billing address ________________________________________________________________________________

City/Town __________________________________________ State__________ Zip Code______________________

Phone: ☐ Voice ☐ VP (________)_________________________________________________________________

E-mail address __________________________________ Fax (______)____________________________

Authorized Signature ______________________________ Date______________________________

After you complete the parts of this form that pertain to you, please mail the form to:
National Technical Institute for the Deaf
Health Care Careers Exploration Camp
52 Lomb Memorial Drive
Rochester, NY 14623

If you prefer to fax the forms, please fax to 585-475-7460.
If you have questions, contact us at: 585-475-7695 or by e-mail at ntidoutreach@ntid.rit.edu