Financial Assistance Form

Name ___________________________________________

Program Fee
The fee for the six-day Health Care Careers Exploration Camp is $700 and includes all 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 below.)
☐ I will seek Vocational Rehabilitation. (Please fill out the information on the next page.)

Scholarship Information  (Must be submitted by April 1, 2017)

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’ 2016 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  ☐ TTY (______) ________________________________ Fax (______) ________________________________

E-mail address _____________________________________________

Authorized Signature _____________________________________ Date__________________
Vocational Rehabilitation

Your local VR office may be able to provide you with a number of state-supported resources related to employment options for people with disabilities. Some states provide funding for programs such as Health Care Careers Exploration Camp (HCCEC) and other services for deaf or hard-of-hearing students starting out on their career search. If you have not done so, now is the time to make the connection with your local VR office. For a list of VR offices in the U.S. visit:

www.ntid.rit.edu/prospective/vr.php

Please have a parent or guardian sign here if you are receiving Vocational Rehabilitation funding.

HCCEC Staff will complete career evaluation information for you based on your attendance at the HCCEC program. VR requires this information if they are financially supporting your participation. Your parent’s or guardian’s signature gives us permission to release this information about you to your VR Counselor.

Signature of Parent/Guardian __________________________________________________________ Date ________________

If VR will be sponsoring you, please have the VR counselor provide the following information.

VR counselor’s name __________________________________________________________

Name of VR office __________________________________________________________

Address of VR office __________________________________________________________

City __________________________ State ________ Zip Code _______________________

Phone: ☐ Voice ☐ TTY (_______) ______________________________________________

E-mail address __________________________________ Fax (_______) ______________________

The office of VR agrees to pay the program fee of $700.00.

VR Counselor’s 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 (voice)
or by e-mail at NTIDOutreach@rit.edu