Arkansas Governor’s Commission on People with Disabilities
2020-2021 Scholarship Application Form

This scholarship is a one-time award for Arkansans with disabilities who are seeking higher education and/or vocational training. If you have received a scholarship from the Governor’s Commission in the past, please do not re-apply since you can no longer receive the scholarship more than once. Also you must be a full-time student accepted into a 2 or 4 year college, university, or vocational training program in Arkansas to be awarded the scholarship.

To Apply: All documents must be turned in or postmarked by February 28, 2020

1. *Completed* and *signed* Arkansas Governor’s Commission on People with Disabilities 2020-2021 Scholarship Application Form.

2. *Completed* and *signed* Arkansas Governor’s Commission on People with Disabilities certification of disability. This form must be signed by a professional health care provider.

3. An official acceptance letter from vocational training program, college, or university confirming applicant’s acceptance or current enrollment (in good standing).

4. Two (2) letters of recommendation from an adult who is not a family member of the applicant. Letters should discuss your academic abilities, character, volunteer services, community involvement, extracurricular activities, and career goals.

5. Official transcript from high school and/or college.

6. First two pages of the previous year’s federal income tax form (for parents or individual).

Please type or print your application. ALL blanks must be completed. Thank you!

Note: If you are unable to complete this form, then you may submit your answers in an alternative format (for example, a recorded video of you answering the questions verbally). If you need extra space to answer a question, then please write the section heading and your full name on top of each extra page used. Have questions? Please call (501) 682-5317.
Arkansas Governor’s Commission on People with Disabilities 2020-2021 Scholarship Application Form

Have you previously received this scholarship? □ Yes □ No

If “yes,” please do not continue this application. You can now only get this scholarship one time. If “no,” please fill out all information in the application below. Thank you!

Contact Information

Name □Mr. □Miss □Mrs.

Date of Birth (MM/DD/YEAR) □ Male □ Female Age

Address

City

State Zip Phone Alt. Phone

Email Address

School Information

Name of School Last Attended

Month/Day/Year of Graduation Click here to enter a date. or GED Click here to enter a date.

School Accepted Into or Currently Attending

Is this school located in Arkansas? □ Yes □ No

Expected Tuition for Chosen School □ per year □ per semester

Are you currently an Arkansas Resident? □ Yes □ No

What do you plan to study at school (your major)?

Do you currently receive accommodations or modifications for school? □ Yes □ No
Financial Need

Select the box for your net family income for the previous tax year (2019)

☐ $0 - $24,999
☐ $40,000 - $54,999
☐ $65,000 - $74,999

☐ $25,000 - $39,999
☐ $55,000 - $64,999
☐ $75,000+

Receive SSI or SSDI? ☐ Yes ☐ No

Number of children in the home [ ] Total number of family members [ ]

Do you have dependents? ☐ Yes ☐ No  If yes, how many? [ ]

Are you planning to get any other scholarships or grants?  ☐ Yes ☐ No

(If “yes,” please list them below.)

<table>
<thead>
<tr>
<th>Name of Scholarship/Grant</th>
<th>Amount</th>
<th>Scholarship or Grant?</th>
<th>Awarded or waiting to hear back?</th>
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Have you been given any other awards or honors? If so, please list below.

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<tr>
<th>Name of Award/Honor</th>
<th>Reason for Award/Honor</th>
<th>Date Received</th>
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Community Involvement

Please list recent (done in past 2-3 years) school, community, and work activities.

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<th>Organization/Group/Employer</th>
<th>Hours/Week</th>
<th>Date(s)</th>
<th>Title/Position</th>
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Personal Statements

These statements help the scholarship committee get to know you and understand your personal goals and specific challenges to continuing your education. Please carefully read the questions and make sure to answer all parts of the questions. Please type or write your responses in the space provided. You may use extra sheets of paper if necessary. Write your full name and the question you are responding to at the top of each extra page used.

(1 of 2)
What is your career goal? What education is needed to achieve this goal? Why are you interested in this career?
(2 of 2)
How has living with a disability affected your life so far (in good and bad ways)?
What challenges have you faced? And what strategies have you used to overcome those challenges?
Application Submission Agreement

Please read the following statement and sign at the end to say that you agree.

I answered all of the application questions honestly. I have been accepted into a school in Arkansas. And I really want to get training to start my career. I understand that I must also send in the below documents for my application to be considered. I understand that all of these documents must be received or sent in the mail (postmarked) by the deadline February 28, 2020:

1. Completed and signed Arkansas Governor’s Commission on People with Disabilities certification of disability. This form must be signed by a professional health care provider.

2. An official acceptance letter from vocational training program, college, or university confirming applicant’s acceptance or current enrollment (in good standing).

3. Two (2) letters of recommendation from an adult who is not a family member of the applicant. Letters should discuss your academic abilities, character, volunteer services, community involvement, extracurricular activities, and career goals.

4. Official transcript from high school and/or college.

5. First two pages of the previous year’s federal income tax form (for parents or individual).

Applicant Signature: ______________________

Date: ______________

Signature of Parent/Guardian if applicant is under the age of 18:

Full name of Parent/Guardian:

Date:

All requested documents MUST be attached with this application; If not, your application will not be considered.

No application forms from previous years will be accepted.


Send completed applications and attachments to:

AR Governor’s Commission on People with Disabilities – Scholarship Committee
PO Box 3781
Little Rock, AR 72203-9537
Scholarship Application Part II, Certification of Disability

This form is to be completed & signed by a Health Care Provider (Please Type or Print Legibly)

Please Check One:  Physician: ___________  Licensed Health Care Provider: ___________

Applicant’s Name: _______________________________________  Date of Birth: ________________

Address: _________________________________________________________________________________

City: _________________________________  State: ____________________  Zip Code: ______________

Medical or Psychological diagnosis(s) of condition(s) causing the applicant’s disability(s):
_________________________________________________________________________________________
_________________________________________________________________________________________

Is this condition permanent? Yes _________  No _________  If no, expected duration? _____/_____/_____

Life Activity Affected (Please check all that apply):  Communication: __________  Learning: __________

Vision: __________  Hearing: __________  Mobility: __________  Other: (________________________)  

Overall Level of Severity/Significance (Please rate by checking):

Most Severe: ____________  Severe: ____________  Moderate: ____________  Mild: _____________

Accommodations and/or Assistive Aids: ______________________________________________________
___________________________________________________________________________________________

Information contained within this application is considered personal and may be protected by both State and Federal laws and regulations. This information is to be treated with the highest degree of confidentiality and may only be exchanged if necessary.

I am knowledgeable of the applicant’s medical and/or psychological condition(s) and based on my professional opinion, I certify that the above information is true and correct.

Name of Provider: ___________________________________________  Telephone #:_____________________

Address: ____________________________________________________________________________________

City: ________________________________________  State: ___________________  Zip Code: ____________

Signature: ____________________________________________________  Date: ________________________
Arkansas Governor’s Commission on People with Disabilities
Consent Form

Name: ___________________________________________________

Address: ___________________________________________________
__________________________________________________

Telephone: ___________________________________________________

E-mail: ___________________________________________________

If awarded a scholarship by the Arkansas Governor’s Commission on People with Disabilities (AGCPD), I hereby provide my written consent to allow the AGCPD to use my photograph and/or information provided by me in my scholarship application file as a way to promote services provided to Arkansans with disabilities by this Commission.

I hereby authorize the Arkansas Governor’s Commission on People with Disabilities and the educational institution at which I will attend to exchange information as required to secure and/or process the scholarship award.

________________________________ ________________
Applicant’s Signature    Date

________________________________ ________________
Parent/Guardian’s Signature (If under 18)   Date