

West Central Iowa Healthcare Foundation
410 Main Street P.O. Box 204
Manning, Iowa 51455
Phone: 712-655-3624 Fax: 712-655-4124
wcihf@mmctsu.com

ARTHUR AND ILA RIX MEMORIAL SCHOLARSHIP APPLICATION

The family of Art and Ila Rix offers two scholarships in the amount of \$500.00 each to be awarded to students pursuing education in a healthcare field. Art and Ila valued education throughout their lives. It is also fitting that these scholarships reward students in healthcare fields due to the personal care Art and Ila received from Manning healthcare facilities.

Please submit the completed application to the Foundation at the above address. The complete application consists of the cover sheets and all required attachments. **The application must be completed, including references, by MARCH 31st.**

1. Full Name of Applicant: _____

2. Address: _____
Street/P.O. Box City State Zip Code
Phone: (_____) _____ Email: _____

3. Date of Birth: _____ Sex : Female _____ Male _____

4. Institution planning to attend: _____
Address: _____
Street/P.O. Box City State Zip Code
Phone: (_____) _____ Will you be a full time student? _____

5. Have you been accepted? Yes ___ No ___ If not, when will you be notified _____

6. What healthcare-related course of study, licensure or certification do you plan to attain?

7. Institution you are currently attending: _____
Address: _____
Street/P.O. Box City State Zip Code

8. When do you expect to graduate/complete your current study? Month _____ Year _____

9. Current employment: _____
Address: _____
Street/P.O. Box City State Zip Code
Position(s): _____ Dates: _____

10. Please describe your healthcare-related experiences: _____

11. Do you or does anyone in your immediate family work at the Manning Plaza, Manning Regional Healthcare Center, Manning Family Recovery Center or Manning Family Healthcare Clinic?
Yes _____ No _____

Who is employed? _____

If not applicant, relationship to applicant: _____

How long have you/your family member worked for one of these agencies? _____

12. If you have attended any other educational institution(s) or training program(s) after high school graduation, please list them here.

Name: _____

Dates attended: _____ Certification received: _____

Address: _____

Street/P.O. Box City State Zip Code

Name: _____

Dates attended: _____ Certification received: _____

Address: _____

Street/P.O. Box City State Zip Code

Name: _____

Dates attended: _____ Certification received: _____

Address: _____

Street/P.O. Box City State Zip Code

13. Please describe what you feel are your personal strengths: _____

14. Please write a brief description of why you are interested in pursuing an education in the healthcare field, your goals and how you plan to attain them. _____

(Please attach additional pages, if needed.)

FINANCIAL NEED:

1. Total annual cost of tuition and books/supplies: \$ _____

2. Total annual cost of room and board: \$ _____

3. Other financial assistance needed: \$ _____

SCHOLARSHIP GUIDELINES:

- Applicant's evidence of a career orientation in a healthcare-related field
- Evidence of acceptance into an accredited healthcare-related program
- Financial need
- Application received prior to March 31, 2011
- Preference given to employees, former employees and family members of the Manning Plaza, the Manning Regional Healthcare Center, the Manning Family Recovery Center and the Manning Healthcare Clinic
- No geographical location requirements
- Include at least two (2) letters of support, one from a supervisor and one from a non-family member
- Applicants may submit any other information believed to be important in an assessment of need and documenting the applicant's benefit to the healthcare field.

This scholarship program is dependent upon the Foundation's allocation of funds for this purpose. Eligible individuals may apply at any time between February 1 and March 31. The review of applications will take place during the month of April. Successful applicants will be notified no later than April 30th. Scholarship support in one grant cycle (fiscal year beginning September 1 and ending August 31) does not guarantee support in subsequent years.

Applicants should understand that a decision by the Grant Review Committee and subsequently by the Board of Directors to decline funding does not necessarily mean that they disapprove of the educational request or that they do not recognize its merit or need. It is the policy of the West Central Iowa Healthcare Foundation not to provide applicants, successful or otherwise, the reasons why a grant was approved or declined.

Scholarship grantees will forward their transcripts to the Foundation after successful completion of their first term following the award. After the Foundation receives the transcript, a check will be awarded and paid directly to the grantee.

PLEASE READ THE FOLLOWING CERTIFICATION/PRIVACY STATEMENT AND SIGN BELOW:

I certify that the information reported on the above application and on any document completed by me in connection with this application is true, correct and complete to the best of my knowledge. I authorize the release and exchange of information between the West Central Iowa Healthcare Foundation and any educational institutions that I have listed in the application and agree that such information exchanged may include, but is not limited to, eligibility, financial enrollment, and identification necessary to assure proper administration of the scholarship. For publicity purposes, I also authorize the West Central Iowa Healthcare Foundation to release my name as an applicant, the schools I have attended or am attending, my current employment, my proposed study major and my award amount if I am a grantee. I further certify that I have read and understand the applicable guidelines and that any willfully false statements made herein may result in my disqualification of current and future awards.

Applicant's Signature: _____ Date: _____