ARKANSAS DEPARTMENT OF WORKFORCE EDUCATION DIVISION OF REHABILITATION SERVICES

Arkansas Governor's Commission on People with Disabilities Scholarship Application Instructions

The Arkansas Governor's Commission on People with Disabilities will award several student scholarships. Applications are graded by the Scholarship Committee on the basis of achievement, community involvement, goals and the challenges each student faces due to his/her disability and recommended to the full Commission for approval. The scholarships recipients will be recognized at a reception in Little Rock. Please follow the directions given below.

PLEASE PRINT OR TYPE YOUR APPLICATION. ALL blanks must be completed. If you have difficulty providing this information in typed or printed form, you may submit an application on audiocassette. If additional space is required, please use a separate sheet of paper. Please write your name, social security number and the section heading with the continuation of your response.

EACH ITEM BELOW MUST BE INCLUDED OR YOUR APPLICATION WILL NOT BE CONSIDERED!

[ ] Completed and signed Governor's Commission on People with Disabilities Application.

[ ] Completed and signed Governor's Commission on People with Disabilities certification of disability form from a health care provider.

[ ] A letter from an official of your school/university confirming that you have been accepted or are currently enrolled and in good standing.

[ ] Three (3) letters of recommendation from an adult who can testify to your academic abilities, character, volunteer services and community involvement.

[ ] Official transcript from high school and/or college.

My check in each of the above boxes indicates that I have provided all necessary information to be considered for an Arkansas Governor's Commission on People with Disabilities Scholarship.

Signature (if over 18) ____ Date ______________

Parent/Guardian ____Date ______________

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

No application forms from previous years will be accepted.
APPLICATIONS MUST BE POSTMARKED BY FEBRUARY 28, 2009
Send completed applications and attachments to:

Arkansas Governor's Commission on People with Disabilities
Scholarship Committee
1616 Brookwood Drive
Little Rock, AR 72202
Telephone (501) 296-1637 V/TDD Fax (501) 296-1883

Arkansas Governor's Commission on People with Disabilities Scholarship Application

Name (Mr.) (Miss) (Mrs.) ____

Date of Birth ____ Age _________

Address ____ City ________________________

State__________ Zip__________ Telephone _____________ E-mail ______________________

Name of school last attended ____

Month/Day/Year of graduation ___________________________ or GED ____________________

Name of college you

(currently attend) (plan to attend) circle one ____

SAT score ___________________ ACT score ________________ GPA____________________

Do you have dependents? If yes, how many? ____

Do you receive SSD or SSDI? _____Yes _____No

Social Security Number ____

Have you previously received a scholarship from the Governor's Commission? ___Yes ___No

Have you received any other scholarships or grants, such as Pell? If so, please list.

	Source	Amount
1)	____________________________________	_______________
2)	____________________________________	_______________
3)	____________________________________	_______________

What is your disability?

____

____

How long? ____

List present and past school involvement.

	Date(s)	Organization	Activity or Position
1)	_________________	_________________	_______________
2)	_________________	_________________	_______________
3)	_________________	_________________	_______________
4)	_________________	_________________	_______________
5)	_________________	_________________	_______________
6)	_________________	_________________	_______________

List community and volunteer activities.

	Date(s)	Organization	Activity or Position
1)	______________________	______________________	________________
2)	______________________	______________________	________________
3)	______________________	______________________	________________
4)	______________________	______________________	________________

How many community volunteer hours do you have? ________________________________

Briefly describe your career goals

____

____

____

What positive or negative effects has your disability had on obtaining your personal goals?

____

____

____

____

____

____

____

____

____

____

If you have any additional information you would like to share, please provide on an attached page.

If under 21, please list parent's names

____

____

I hereby attest that all information submitted in this application is true and correct to the best of my knowledge.

Applicant Name______________________________________ Date ________________

Parent's signature if under 18 ____

Arkansas Department of Workforce Education
Division of Rehabilitation Services
Arkansas Governor's Commission on People with Disabilities
1616 Brookwood Drive
Little Rock, AR 72202
Telephone: (501) 296-1637 V/TCDD
Fax: (501) 296-1883

Scholarship Application Part II, Certification of Disability

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

Please Check One:
[ ] Physician [ ] Licensed Health Care Professional [ ] Rehabilitation Counselor [ ] Other

Applicant's Name ____________________________________ Date of Birth _______________

Address ____

City ___________________________ State______________ Zip Code ___________________

County ______________________________________

Medical diagnosis of condition causing applicant's disability

____

____

____

Is this a permanent condition? ____Yes _____ No If no, expected duration ____/_____/____

Life Activity Affected	Severity/Significance	Assistive Aids
Vision	__________________________________	______________________
Hearing	__________________________________	______________________
Communication	__________________________________	______________________
Mobility	__________________________________	______________________
Other (_________)	__________________________________	______________________

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

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

Name of the Care 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, I hereby provide my written consent to allow the Arkansas Governor's Commission on People with Disabilities 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's/Guardian's Signature (if under 18) Date