South Dakota Health Care Association℠

Assisted Living Association℠ Senior Living Association℠

$2,000 Scholarship Application Packet

The SDHCA Scholarship Committee will review and award scholarship(s) to qualified individuals who are advancing his/her education and practice in the long term health care profession. **This scholarship requires a match by the employer.**

$1,000 will be awarded by SDHCA to each qualified scholarship recipient.
An additional $1,000 will be awarded by the scholarship recipient's employer.

This scholarship will be awarded for the Fall 2023 Semester. Only complete application packets will be considered that include the College Acceptance Letter, Employer Reference Form and Personal Reference Form.
Online application available here.

Please complete the entire application packet including the reference forms and return to South Dakota Health Care Association (SDHCA), 804 N Western Avenue, Sioux Falls, SD 57104 no later than **July 20th.**

Reference forms should be given to contacts of your choice for them to return to our office. The completed Application Packet and a copy of your College Acceptance Letter that you are attending Fall 2023 **must be returned to the SDHCA office by July 20th.**

PLEASE PRINT OR TYPE ALL INFORMATION

Name_____ Email:_____

Address _____City, State, Zip _____

Telephone or Cell # _____

Current Employment Information:

Name of Facility _____ City _____

Position _____ Date of Employment _____

Name of Supervisor_____

List college/university/correspondence course program which you are attending or have been accepted: _____

College City, State, Zip _____

Name of major/degree you are enrolled in: _____

How many quarters or semesters have you completed? _____

How many credit hours per quarter or semester? _____

How many credit hours will you take? _____What is your grade point average? _____

Have you had any other special training related to long term health care? If so, please explain:

_____

_____

_____

_____

Please describe your interest in long term health care, including how you became interested in the profession and related experiences you have had:

_____

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Please describe your future professional plans in the health care field and your commitment to the long term health care field:

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College Acceptance Letter

Applicant: Please provide us with a copy of your College Acceptance Letter that you will be attending in Fall 2023.

Scholarship Agreement

As the recipient of the SDHCA scholarship, you agree to the following conditions of the scholarship program. These conditions are:

- Recipient agrees to work full-time for one year in an SDHCA Member Center upon completion of his/her higher education.

- The recipient will be in contact with the SDHCA Member Center during his/her higher education training and will report to the SDHCA Member Center upon completion of training.

- If the recipient does not work the required one-year after finishing school, then he/she agrees to pay back SDHCA at a rate of $100.00 per month for each month not worked upon completion of his/her higher education.

Verification:

If I, _____, am awarded the SDHCA scholarship, I pledge to work in an SDHCA Member Center for a minimum of one year upon graduation.

Along with a copy of your College Acceptance Letter, please include the following signed statement:

You are verifying that you will indeed be attending the following college the Fall 2023 Semester.

Name of College you will be attending: _____

Print Your Name: _____ Your Signature _____

_____ _____

Witnessed by Dated

Completed SDHCA Scholarship Application packet must be received in the SDHCA office no later than July 20th .

Send to: South Dakota Health Care Association
804 N Western Avenue
Sioux Falls, SD 57104-2098

SDHCA Scholarship Application Packet

Employer Reference Form

SDHCA will review and award $1,000.00 scholarship(s) to qualified individuals who are advancing his/her education and practice in the long term health care profession. This scholarship will be awarded for the 2023 Fall Semester.

We appreciate your help in selecting the recipient of this scholarship. **This reference form must be returned to SDHCA and must be received by July 20th .**

Return forms to:

South Dakota Health Care Association
804 N Western Avenue
Sioux Falls, SD 57104-2098

All references and recommendations are kept confidential. **Failure to respond prior to the deadline will disqualify applicant from being considered.**

PLEASE PRINT OR TYPE ALL INFORMATION

Name of applicant _____

Name of reference _____Phone number of reference_____

Title or position of reference_____

Address, City, Zip of reference _____

How long has the applicant worked in your Center? _____

How would you rate the applicant on the following?

	Low	Average	High
Maturity	____	____	____
Sensitivity to Residents' Needs	____	____	____
Commitment to Long Term Care	____	____	____
Ability to Communicate	____	____	____
Leadership Skills	____	____	____
Interpersonal Relationships	____	____	____
Attendance Record	____	____	____

Briefly describe why you believe this applicant would be a worthy recipient of this scholarship:

_____

_____

_____

Signature of Employer _____ Date _____

Employer Matching Scholarship Pledge Instructions

Student's Name _____

Name of Nursing Facility or Assisted Living Employer_____

Address _____City_____State_____Zip_____

Phone Number _____

E-mail Address _____

Employer Financial Match Agreement: If this applicant is chosen to receive a SDHCA Scholarship, as the employer, we do hereby agree to invest in the education of this applicant by matching SDHCA's scholarship in providing a monetary pledge toward the higher education training fees of the above-named student in the amount of $1,000 for enrollment of the 2023-24 semesters. Refer to the Scholarship Agreement section of this scholarship application for more details.

Who is the Nursing Facility or Assisted Living contact person for this student who is signing that the facility will provide a monetary match of $1,000 should this applicant be qualified as a SDHCA Scholarship recipient:

Facility Contact Person's Name _____

Official Facility representative Signature _____

Contact Person's E-mail _____

Contact Person's Phone _____

SDHCA Scholarship Application Packet

Personal Reference Form

SDHCA will review and award $1,000.00 scholarship(s) to qualified individuals who are advancing his/her education and practice in the long term health care profession. This scholarship will be awarded for the 2023 Fall Semester.

We appreciate your help in selecting the recipient of this scholarship. **This reference form must be returned to SDHCA and must be received by July 20th .**

Return forms to:

South Dakota Health Care Association
804 N Western Avenue
Sioux Falls, SD 57104-2098

All references and recommendations are kept confidential.

Failure to respond prior to the deadline will disqualify applicant from being considered.

PLEASE PRINT OR TYPE ALL INFORMATION

Name of applicant _____

Name of reference _____Phone number of reference_____

Title or position of reference_____

Address, City, Zip of reference _____

What is your relationship to the applicant? _____

How long have you known the applicant? _____

Briefly describe why you believe this applicant would be a worthy recipient of this scholarship:

_____

_____

_____

_____

Signature of Reference _____Date _____