SCHOLARSHIP APPLICATION

The Kūpuna Aging in Place (KAP) for Elderly Services Program

STATEMENT OF PURPOSE

The purpose of the Kūpuna Aging in Place for Elderly Services Program is to provide financial assistance to current or potential Adult Day Health by Hale Makua clients who cannot afford to attend the Program the number of days that they would benefit from.

AMOUNT OF SCHOLARSHIP

Subsidy scholarships for Adult Day Health by Hale Makua will be distributed monthly throughout 2021, as long as funds are available.

SCHOLARSHIP CRITERIA

Adult Day Health by Hale Makua clients selected for financial assistance will meet the following criteria. They must:

1. Be a Hawai'i resident
2. Be able to show proof of financial need
3. Be 65 years of age or older
4. Qualify for Adult Day Health Services*

* If applicant qualifies for Adult Day Health Services under Medicaid/QUEST (i.e. Ohana, Evercare) or Veterans Affairs, they will NOT qualify for this scholarship.

CONTACT INFORMATION

Please return completed Scholarship Applications to the following address:

Hale Makua - Adult Day Health
472 Kaulana Street
Kahului, HI 96732
Attn: Jodi Horton

For questions or inquiries, please contact Jodi at (808) 871 - 9287
or jodi.horton@halemakua.org.

SCHOLARSHIP APPLICATION

Please print in ink or type all information.

Month / Year you are applying for: _____

1. Personal Information

Full Name: _____ SS#: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Residential Address (if different from above): _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Current Age: _____ Date of Birth: _____ Marital Status: _____

Is there anyone sharing your household expenses with you? Yes _____ No _____

Do you have relatives living in the area? Yes __ ___ No __ ___

If yes, what assistance do they provide you? (Check all that apply)

_____ Housing _ __ Transportation _ __ Financial Help

_____ Other _ __ None

2. Financial Information

a. What are your average monthly expenses? (Please list dollar amount)

Housing	$ _____
Utilities (electric, gas, phone, water, etc.)	$ _____
Food	$ _____
Transportation (gas, maintenance, bus fare)	$ _____
Insurance coverage	$ _____
Loan payments	$ _____
Monthly payments	$ _____

Clothing, household goods $ _____

Medical costs (prescriptions, dentist, etc.) $ _____

Other expenses (please list)

_____ $ _____

_____ $ _____

_____ $ _____

Total Average Monthly Expenses **$ _____**

b. Are you covered by any health or medical insurance? Yes _____ No _____

If yes, which one(s) _____

c. Please list sources of income in dollar figures in **Column A** if you derived income from that source in the **last 12 months.**

In **Column B**, list the dollar amount of sources of income that you will derive income from in the **next 12 months. <u>If column B is not completed, we cannot process your application.</u>**

Please include ALL sources on income such as food stamps, HUD, other scholarships, etc.

Source of Income	**Column A (Last 12 Months)**		**Column B (Next 12 Months)**	
	Per Month	**Per Year**	**Per Month**	**Per Year**
Friends				
Family				
Employment				
Reserved Armed Forces				
Unemployment				
Social Security				
Rehabilitation				
HUD Rental Assistance				

Child Support				
Food Stamps				
V.A.				
Loans				
Scholarships				
TOTAL				

Other grants or sources of income (please list): _____

_____

Total household income for **past** 12 months: $ _____

Total household income for **next** 12 months: $ _____

(Optional) Please include here anything else about your financial situation that would be helpful in evaluating your application in the space provided: _____

_____

_____

_____

_____

3. Additional Questions

a. Are you a current/returning client of Adult Day Health by Hale Makua? Yes No

If you answered yes above, please answer the below questions:

i. How times per week do you attend? _____

ii. How long have you be enrolled in the program? _____

iii. Why do you want to attend more frequently? _____

_____

_____

b. How will you and/or your family members benefit from you attending Day Health?

_____

_____

c. Please describe any health related goals for you (your family member) that you hope Adult Day Health can help achieve?

4. Additional Documentation

- Copy of your most recent Federal Tax Return (form 1040) with all schedules
- Copy of your latest pay stub or retirement income for both husband and wife, where applicable

Attestation

I agree that if there is any change in the information contained herein (increase in income, spouse becoming gainfully employed, etc.) that I will notify the Head LPN of Adult Day Health by Hale Makua. As a result of said change, or if the Scholarship Committee becomes aware of some material discrepancy between the information submitted herein and the facts, the Committee may revoke all or part of this Scholarship at their discretion and I agree that amount will become my obligation.

The information contained herein is correct tot the best of my knowledge and belief. I understand that Hale Makua Health Services reserves the right to request additional information in the future if deemed necessary.

Signature of Applicant **Date**

Below to be completed by Hale Makua Health Services.

Reviewed by Adult Day Health Program Manager **Date**

Approved by Director of Communications & Development **Date**