



**Community Action Partnership
of North Central Missouri (CAPNCM)**

1506 Oklahoma Avenue ~ Trenton, MO 64683

Phone: 1-855-290-8544 ~ Fax: 1-844-503-1872

Website: www.capncm.org

E-mail: contactus@capncm.org

Dear Applicant,

Thank you for your interest in the Community Action Partnership of North Central Missouri (CAPNCM) Scholarship. We are pleased to offer this scholarship to both new and post graduate students continuing their education beginning in the summer or fall of 2016.

In order for this scholarship to be presented in a timely fashion, it is very important that you complete the following paperwork as soon as possible. **CAREFULLY REVIEW THE FOLLOWING PAGE BEFORE YOU COMPLETE THIS APPLICATION.** These requirements must be met in order to be eligible for the scholarship. You should carefully review the application and the agreements section before signing and submitting.

Deadline for receiving completed applications in our offices is April 8, 2016 @ 5:00pm.

You may deliver your application in person to Community Action Partnership of North Central Missouri (CAPNCM) located in Trenton, Missouri or mail it to 1506 Oklahoma Avenue Trenton MO 64683 Attn: CAPNCM Scholarship Program. This application may also be submitted by emailing the completed paperwork to: ssummers@capncm.org

In order to be considered for this scholarship you must submit an acceptance letter or class schedule from the college or trade school you have chosen to attend.

The actual scholarship check will be made payable to the recipient. Any decisions of the selection committee will be final.

Sincerely,

A handwritten signature in black ink, appearing to read "Savannah Summers".

Savannah Summers, Community Services Director
Community Action Partnership of North Central Missouri

Rules & Guidelines

CAPNCM will award up to eighteen (18) scholarships across our nine (9) county service region in the amount of \$1,000 per scholarship, per school year.

A committee comprised of CAPNCM staff and Board members will select the grantees. Scholarships will be awarded to up to eighteen (18) applicants who are, in the opinion of the committee, most deserving of the award from submissions received.

Scholarship Applicants should complete pages 3-5, including all essay questions. Parents/Guardians (if applicant is a minor) should complete pages 6-9 of the scholarship packet to the best of their ability and include social security cards for all members of the household and 30 days' worth of pay stubs for any working members of the household.

Incomplete and/or late applications will not be considered. Please include all required and signed paperwork, including a copy of your college or trade school acceptance letter when submitting this scholarship application.

Eligibility

Applicants should reside full-time within one of the following Missouri counties: Caldwell, Daviess, Grundy, Harrison, Linn, Livingston, Mercer, Putnam, or Sullivan and live in an income-qualified household (income qualification to be determined by pages 6-9 of this packet).

Applicants should be qualified for admission to an accredited college, university, or trade school. A minimum of a 2.5 GPA must be maintained to be considered to receive this scholarship.

Both traditional and non-traditional students are welcome to apply.

Application deadline:

Checklist

- CAPNCM Assessment Form*
- Scholarship Information and Essay Questions
- College, trade or vocational school acceptance letter and/or class schedule
- Proof of income for the past 30 days for each member of your household*
- Copy of Social Security cards of everyone residing in your household*

**to be completed/provided by parent/guardian if applicant is under 18*

I agree that all requested information contained in this application is attached and accurate.

Signature of Applicant

Date

Signature of Parent or Guardian (if under 18)

Date

All questions must be answered fully and accurately. Please type or print in ink.

Name _____
Date of Birth

Address

City _____ _____ _____
State Zip County

Home Phone _____
Cell

High School _____
Graduation Date

GPA at time of graduation _____
College entrance score (ACT/SAT)

Name of college you plan to attend _____
Planned Major

Do you currently have any college credit hours? Yes No If so, how many? _____

Family Information

Mother/Guardian Name _____
Father/Guardian Name

Address _____
Address

City, State, Zip _____
City, State, Zip

Occupation _____
Occupation

Telephone _____
Telephone

School activities, organizations, offices held, etc:

Community activities, community service projects, organizations, offices held, etc:

Other scholarships received/applied for and amounts of:

Your life goals during and after college:

Please attach high school transcript.

Student Signature

Date

Parent/Guardian Signature

Date

Parent/Guardian Please Complete This Section

Please list all members of your household below.

Name (First, Last)	SSN	DOB	M/F	Relation	Race	Health Insurance Type	Veteran (Y/N)	Highest Education Level	Disabled (Y/N)	Hispanic Latino (Y/N)
				self						

Attach additional sheets of paper if necessary for listing additional household members.

List **ALL** income sources – wages, self-employment, social security, SSI, child support, TANF, etc.

Household Member's Name	Source of Income	Amount of Income	How Often Received

Do you spend too much on utilities?

Do you wish your housing situation could be improved?

Do you need more food?

Are you dissatisfied with your employment/education situation?

Do you or your family have any health issues?

Are you currently facing any emergencies?

Do you need assistance with childcare?

Do you need transportation assistance?

Client Confidentiality Agreement / Release of Information / Media Waiver

I certify that the information given on this application is true and accurate to the best of my knowledge and belief. I understand that such information is subject to verification and I further realize that falsified or fraudulent information may result in the rejections of this application.

Under the terms of this Agreement, CLIENT agrees to release to CAPNCM information that is confidential and proprietary to CLIENT (Confidential Information), to be used solely for the Agency's related statistics, services, and programs. Confidential Information refers to any and all information of a confidential, proprietary, or secret nature which is or may be related in any way to the family, medical records, job history, present or future, or CLIENT, or any related data. Confidential Information included, for example, but not limited to: spouses or other family members, ages, salaries, financial standings, criminal records, medical records, and all other pertaining to the family information.

CAPNCM will consider all information received from CLIENT to be strictly confidential, as required by the Privacy Act, and subject to the restrictions of this Agreement; except for information that is: (i) generally known to the public, (ii) in the possession of CAPNCM before receipt from CLIENT, (iii) obtained later by the Agency from a third party without restriction or violation of Agreements.

CAPNCM will not disclose CLIENT's Confidential Information to any other party without the prior written consent of CLIENT, CAPNCM may, however, disclose Confidential Information to its employees and/or programs but only if the employee has a legitimate need to know and has agreed to terms similar to those in this Agreement. CAPNCM may also disclose this Confidential Information (i) to medical personnel in an emergency; (ii) to qualified personnel for research, audits, or program evaluation, as long as CLIENT identities are not identified; (iii) to a third party based on court orders; and (iv) to appropriate authorities in cases of suspected child abuse or neglect. CAPNCM will be responsible for any use or disclosure of Confidential Information by any of its employees or agents to third parties who should not share this information.

I also hereby grant permission to CAPNCM to use my image (photographs and/or video) for use in CAPNCM publications including videos, email blasts, recruiting brochures, newsletters, and magazines and to use my image in electronic versions of the same publications or on the CAPNCM website or other electronic forms of media.

I hereby waive any right to inspect or approve the finished photographs or electronic matter that may be used in conjunction with them now or in the future, whether that use is known to me or unknown, and I waive any right to royalties or other compensation arising from or related to the use of the image.

Please check the paragraph below which is applicable to your present situation:

____ I am 18 years of age or older and I am competent to contract in my own name. I have read this release before signing below, and I fully understand the contents, meaning and impact of this release.

____ I am the parent or legal guardian of the below named child. I have read this release before signing below, and I fully understand the contents, meaning and impact of this release.

Client Signature: X _____ Date: _____

Child's Name (if applicable): _____ Date: _____

Interviewer's Signature: _____ Date: _____

Client Consent – Release of Information

The Missouri Community Action Management Information System (MIS) serves Missouri’s Community Action Agencies, a network of partner agencies working together to provide service to low-income individuals and families in Missouri.

The information that is collected in the (MIS) database is protected by limiting access to the database and by limiting with whom the information may be shared, in compliance with the standards set forth in the Health Insurance Portability and Accountability Act (HIPAA). Every person and agency that is authorized to read or enter information into the databases has signed an agreement to maintain the security and confidentiality of the information. Any person or agency that is found to violate their agreement may have their access rights terminated and may be subject to further penalties.

BY SIGNING THIS FORM, I AUTHORIZE THE FOLLOWING:

I authorize the partner agencies and their representatives to share the following information regarding my family/household and me. I understand that this information is for the purpose of assessing our needs for employment, housing, utility assistance, food, counseling and/or other services.

The information may consist of the following:

- My financial situation, to include the amount of my income, savings of money and/or food stamps I may have.
- This information may also include debts I owe for utilities, rent, etc.
- Identifying and/or historical information regarding myself and members of my family/household.

I UNDERSTAND THAT:

- Information I give concerning physical or mental health problems will not be shared with other partner agencies in any way that identifies me.
- The partner agencies have signed agreements to treat my information in a professional and confidential manner. I have the right to view the client confidentiality policies used by the MIS.
- Staff members of the partner agencies who will see my information have signed agreements to maintain confidentiality regarding my information.
- I have the right to request information about who has accessed my information.
- The partner agencies may share non-identifying information about the people they serve with other parties working to end poverty.
- The release of my information for the MIS does not guarantee that I will receive assistance, and my refusal to authorize the use of my identifying information does not disqualify me from receiving assistance.
- This authorization will remain in effect unless I revoke it in writing, and I may revoke authorization at any time by signing a written statement available at any partner agency.
- If I revoke my authorization all identifying information already in the database will remain, but will no longer be shared with partner agencies.

Partner Agencies: A list of the partner agencies within the Statewide Community Action Network may be viewed prior to signing this form.

Client Name (please print) X _____
Client Signature _____
Social Security Number

Agency Personnel Name (please print) _____
Agency Personnel Signature _____
Date