

## Partnership HealthPlan of California Member Scholarship Program Application

**PLEASE TYPE OR CLEARLY PRINT YOUR ANSWERS.**

1.	Name ( <i>First, MI, Last</i> ): _____														
2.	Date of Birth (mm/dd/yyyy): _____														
3.	Street Address: _____ City: _____ State: _____ ZIP: _____														
4.	Telephone Number: _____	4.	Email: _____												
6.	<p>Are you a current Partnership member or former member?</p> <p><input type="checkbox"/> I am a current member. <input type="checkbox"/> I am a former member.</p> <p style="text-align: center;">Last date of membership: _____</p>														
7.	<p><b>If you are under 18</b>, please provide the name and address of parent(s) or legal guardian(s):</p> <p>Parent(s) or Guardian(s): _____</p> <p>Street Address: _____</p> <p>City: _____ State: _____ ZIP: _____</p> <p>Phone: _____ Email: _____</p>														
<b>EDUCATION</b>															
8.	<p>High school: _____ City, State: _____</p> <p>Year of Graduation: _____ <input type="checkbox"/> I hold a GED instead of a high school diploma.</p> <p>Describe any additional education you may have received below:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 35%;">Name of Institution</th> <th style="width: 35%;">Dates Attended</th> <th style="width: 30%;">Year Graduation and Degree (if applicable)</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>			Name of Institution	Dates Attended	Year Graduation and Degree (if applicable)									
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9. Please indicate whether you are currently enrolled in, have been accepted to, or have applied to a higher education institution. Include the name of the school.

Enrolled    Name of higher education institution: \_\_\_\_\_  
Student ID #: \_\_\_\_\_

Accepted    Name of higher education institution: \_\_\_\_\_  
Student ID #: \_\_\_\_\_

Applied    Name of higher education institution: \_\_\_\_\_  
Student ID #: \_\_\_\_\_

**Proof of acceptance or current student enrollment from the school is required prior to receipt of funds.** For example, applicant may be asked to provide a copy of the letter of acceptance from the higher education institution, a transcript if currently enrolled, or similar documentation.

10. What specialty/major are you pursuing, or planning to pursue, in your education?

11. List and briefly describe any work experience you may have.

<i>Position</i>	<i>Employer</i>	<i>Dates of Employment</i>	<i>Duties</i>

12. List any academic honors or awards you have received.

13. Briefly list community-related activities or hobbies that you have been involved in through your school, church, or other organization.

**ESSAY QUESTIONS**

Please answer the following questions. Please submit your responses on separate paper (or in a separate document) and attach to this application.

1. How will your studies further your plans for a career in the health care and/or human/public/social services fields? And what are your career goals? [500 words]
2. How has Partnership HealthPlan of California been a partner in your health/life? (This can be medical care, services, and/or supports that Partnership has helped provide.) [500 words]
3. Is there anything else you want to share that makes you a good candidate to receive this award that has not been included in your application already? [250 words]

**CONFIDENTIALITY WAIVER, ESSAY RELEASE AND STATEMENT OF ACCURACY**

I hereby affirm that all the above stated information provided by me is true and correct to the best of my knowledge.

I hereby give *Partnership HealthPlan of California* permission to release any information provided by me in this application to the Partnership Member Scholarship Program Selection Committee.

I hereby grant *Partnership HealthPlan of California* permission to use the essay responses provided by me in this application for all purposes and in perpetuity. I waive the right to inspect or approve versions of the essay responses.

I hereby understand that if chosen as a scholarship winner, according to Partnership HealthPlan of California Member Scholarship Policy and Procedures, I must provide evidence of enrollment/registration at the education institution of my choice before scholarship funds can be awarded.

I hereby understand that if chosen as a scholarship winner, I will agree to provide a photo that Partnership can use to identify me as the winner in its announcement and any such publicity materials related to the scholarship.

Signature of scholarship applicant: \_\_\_\_\_ Date: \_\_\_\_\_

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**REMINDER**

All applications must be received by **March 18, 2026** to be considered.

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