

KHCA/KCAL Joan Hamel Nursing Scholarship Application Information

DATE: January 2, 2019

TO: All KHCA and KCAL Member Facilities

The Kansas Health Care Association's Nursing Advisory Committee (NAC) is pleased to sponsor the Joan Hamel Nursing Education Scholarship Program. KHCA will award up to \$2,000 in scholarship grants to KHCA or KCAL member facility employees who wish to begin or continue a nursing education program in the 2018 school year.

Applications for scholarships will be accepted in the KHCA/KCAL office at 1100 SW Gage Blvd., Topeka, KS 66604 or by fax at 785-267-0833. Only one scholarship per facility may be awarded per academic year. The scholarship recipients will be selected by the Nursing Advisory Committee at their next meeting following receipt of the application and the recipients will be notified by KHCA/KCAL. The applications will be reviewed based on the following factors:

- ◆ **Facility Scholarship** - Applicants must first receive a scholarship from the sponsoring KHCA/KCAL member facility. The KHCA/KCAL Joan Hamel Nursing Scholarship Fund will match, **up to \$500 per semester**, the scholarship funds received from the sponsoring facility. For LPN, up to two semesters may be approved. For RN programs, up to four semesters may be approved.
- ◆ The NAC board retains the prerogative to approve non-traditional nursing education for payment through the Joan Hamel Scholarship funds. **Funds are not available for fulfilling prerequisite classes.**
- ◆ **Academically Accepted - The facility may submit an application prior to acceptance into a school of nursing.** Applicant must be accepted to an accredited school of nursing within twelve months of the scholarship selection for the funds to be awarded. The scholarship will be sent directly to the school of nursing at the appropriate time following verification of acceptance of the student into the program. Applicant must remain academically eligible for the second semester in order for the second half funds to be dispensed.
- ◆ **Employment Agreement** - Applicant must agree to work in the sponsoring facility for a minimum of one year after graduation or for a period of time deemed reasonable and appropriate by the sponsoring facility. The sponsoring facility may require a longer post-graduation employment period.
- ◆ **Educational Endeavor** - Applicants will not be discriminated against based on level of educational endeavor other than those imposed by the facility.
- ◆ **Requirements** - Applicants must include letters of recommendation from the administrator and DON, along with two letters of recommendation from two non-work related persons. Recommendations from the applicant's family members and/or relatives will not be accepted. Selection of applicants is at the discretion of the KHCA Nursing Advisory Committee. However, all selection decisions and awards shall be made without regard to race, creed, color, national origin, sex, age or disability.

- ◆ **Scholarship Application Form and Narrative** Applicants must submit a completed application to include a narrative testifying as to the need for financial assistance and desire to pursue or further her/his nursing education.
- ◆ **Repayment Provision** - Applicant must agree to the terms and conditions for the receipt of the KHCA scholarship grant as specified in the bond agreement.
- ◆ **Incomplete Applications** - Only applications that are submitted complete with attachments as described above will be considered by the scholarship selection committee. Incomplete applications will not be reviewed and will be returned to the facility.

Enclosed are the following:

- ◆ **Application Form** - The application form must be completed by the applicant, endorsed by the sponsoring facility, and returned to the KHCA/KCAL office.
- ◆ **Bond Form (Sample)** - If the applicant is selected for a scholarship, this bond agreement will be sent to you for completion by the applicant and the sponsoring facility. The facility is required to serve as a surety on the KHCA/KCAL scholarship grant in the event the applicant defaults and fails to complete the course of study and the length of employment as required by the facility. The facility must also agree to maintain its membership in KHCA/KCAL during the period of obligation under the bond. Before funds can be sent to the school of nursing, KHCA/KCAL must have the bond agreement on file.

APPLICATION FOR KHCA/KCAL JOAN HAMEL NURSING SCHOLARSHIP

DATE: _____

PERSONAL DATA

Name and Address of Applicant: _____

Social Security Number: _____

Name/Address of Sponsoring Facility: _____

Name of Facility Administrator: _____

Name of Facility DON: _____

Length of Employment at Sponsoring Facility: _____

Employment Position in Facility: _____

SCHOLARSHIP INFORMATION

Amount of Scholarship Granted by Facility: \$ _____

Amount of Matching Funds Requested from Joan Hamel Nursing Scholarship Fund
(Maximum \$500 per Semester): \$ _____

Scholarship Requested for _____ School Year/Semester.

Name/Address of School Applicant will be accepted at: _____

Anticipated Date of Acceptance/Acceptance Date: _____

Contact Person at School Responsible for Accepting Scholarship Funds: _____

Type of Degree Sought: _____

Estimated Length of Study to Complete Degree Requirement: _____

Upon completion of my nursing education, I agree to work for the adult care home or long-term care facility that is sponsoring my application for the length of time as specified on the bond agreement, which is attached hereto. I further agree to reimburse the KHCA/KCAL Joan Hamel Nursing Scholarship Fund the full amount of the scholarship granted if I do not complete the program for which this scholarship is granted.

Signed: _____

(Applicant)

(Attach letters of recommendation from the sponsoring facility administrator and DON -- one page maximum, and two letters of recommendation from non-work related persons. Also attach handwritten narrative as described in "Application Information.")

APPROVAL AND AGREEMENT BY SPONSORING FACILITY

This application is sponsored and approved by the named Sponsoring Facility which agrees: (1) to be the surety on the bond of the applicant; and (2) to maintain its membership in THE KANSAS HEALTH CARE ASSOCIATION, INC. during the period of the obligation under the bond.

Dated: _____

(Please type name and address of facility followed by the signature of its responsible officer)

Facility Name

Facility Address/City/Zip Code

Signature of Responsible Officer

**Kansas Health Care Association/Kansas Center for Assisted Living
JOAN HAMEL NURSING SCHOLARSHIP FUND BOND**

I, Kayla Rodriguez of 791 E 510th Ave. of the City of Pittsburg, County of Crawford State of Kansas as PRINCIPAL, and Medicaloges Pittsburg – 2520 S Rouse St. City of Pittsburg, County of Crawford, State of Kansas as SURETY, acknowledge our indebtedness to THE KANSAS HEALTH CARE ASSOCIATION, INC. of 1100 SW Gage Blvd., Topeka, Kansas 66604, in the sum of \$500/semester, totaling \$2000.00, together with interest thereon at the rate of 5% per annum from the date hereof to be paid on the 15th day of August, 2018__ which sum represents the sum advanced to the PRINCIPAL by the ASSOCIATION for which payment, well and truly to be made, we bind ourselves our heirs, executors, administrators, legal representatives, and successors jointly and severally.

The CONDITIONS of this obligation are: (1) that if the PRINCIPAL shall complete the course of study stated in his/her application for a scholarship grant (a copy of which is attached) and obtains a license in the State of Kansas to practice _____ and thereafter completes 12 months in the employment of the SURETY practicing the occupation as qualified under the said license, and; (2) the SURETY maintains its membership in THE KANSAS HEALTH CARE ASSOCIATION, INC. during the period of the obligation of this bond, then, the above obligation is to be NULL AND VOID; otherwise, on the failure to fulfill any of the conditions, the obligation shall remain in full force and effect.

IN WITNESS WHEREOF, the PRINCIPAL and SURETY have executed this

instrument at _____

(Designate place of execution)

this _____ day of _____, 20__.

(Type or print name and residence)

(Sponsoring facility)

Medicalodges Pittsburg

(Type name and address, followed by the

signature of the responsible officer of

the sponsoring facility)