

The HealthCare Chaplaincy
Financial Aid Request Form
Clinical Pastoral Education

*program applied for

Today's Date: _____	Candidate:	Program applied for:
Name _____		Full Time Unit (11 Weeks)
Present Address _____		<input type="checkbox"/> Winter <input type="checkbox"/> Spring <input type="checkbox"/> Summer <input type="checkbox"/> Fall

_____ Phone _____		Extended Unit (Part-time, 20 weeks or longer)
Permanent Address _____		<input type="checkbox"/> fall start <input type="checkbox"/> winter start <input type="checkbox"/> spring start

_____ Phone _____		Residency Applicants:
Social security number _____		Residencies are automatically stipended and there is a
Date of birth (optional) _____		health insurance option. This form is only to be
E-mail address: _____		submitted by extended and full-time student applicants.

Your current employment status (include student work-study as employment):

Full time employed Part time employed Not currently employed

Employer business name:

Employer address/phone number:

Supervisor name:

Annual Household income (include income from other household members):

\$40,000 and up \$30-\$40,000
 \$20-\$30,000 \$10-20,000 under \$10,000

Do you have dependent family members?

No
 Yes (please indicate how many, excluding yourself): _____

Please describe: _____

Are you currently a student elsewhere?

No
 Yes
Please describe: _____

Are you in a school or congregation which might provide partial or full coverage of your HealthCare Chaplaincy tuition?

No
 Yes

If yes, please provide a name and phone number for the person at your school or other organization, whom we may contact to ask about partial or full coverage of your HealthCare Chaplaincy tuition:

