



Bogart HOPE Scholarships

Sponsored by Fred Kunik and Susan Greenberg Kunik and Western Union

Application Packet

What is the Bogart HOPE scholarship?

It is a scholarship program that awards stipends to cancer survivors to support higher education in (1) college, (2) vocational school, or for their (3) continuing education (life-long learner). The scholarships are for tuition, fees, books and supplies. This year, we are pleased to offer 15 scholarships of \$2000 each. Each recipient will also receive a laptop computer.

Who is eligible for the Bogart HOPE Scholarship Program?

Students accepted or enrolled in college, vocational school, or a course of study who:

- ✓ Are cancer survivors diagnosed before the age of 21
- ✓ Received their treatment or HOPE program care at Children's Hospital Los Angeles

What is expected of Bogart HOPE Scholarship recipients?

- ✓ Scholarship recipients are expected to attend the HOPE Program's "Celebrate Life with HOPE" event on June 5th where the scholarships will be presented
- ✓ Scholarship recipients may be asked to communicate with HOPE Program donors and/or HOPE Program staff
- ✓ Scholarship recipients are expected to serve 12 hours as a HOPE Program volunteer. Activities may include: serving as a HOPE Program spokesperson, participating in fundraising/awareness events such as Celebrate Life, and others

What criteria are used in evaluating Bogart HOPE Scholarship applications?

- ✓ Applicant need
- ✓ Determination, ability to overcome the odds
- ✓ Educational and life goals
- ✓ Academic performance
- ✓ Community service will be considered but is not required

If you have any questions, please stop by
the HOPE Resource Center at CHLA (5th Floor Outpatient Tower)
or call us at 323-361-2508.

Bogart HOPE Scholarship 2011 - Application Checklist

- Application Form.** All information on the form must be completed for the application to be considered. You may use photocopies of the form.
- Quotable Statement.** Please tell us in 75 words or less what being awarded the Bogart HOPE Scholarship would mean to you.
- Essay.** Please write your answers for the topics **a, b and c** listed below. Each answer must not be longer than 200 words and must be typewritten, and clearly labeled with the specific topic title (*a. Goals, b. Life Experience, and c. Community Service*) and the applicant's name.
 - **Goals:** Please describe your education, vocational training, or continuing learning plans. Tell us about your possible career plans.
 - **Life Experience:** Please tell us how perseverance, courage, or self-reliance have influenced your life. Please describe your successes in spite of challenges or disabilities (physical, financial, medical, etc). Tell us how your life experiences have prepared you for future goals.
 - **Community Service:** Please tell us about any volunteer work you have done for individuals, groups, organizations, schools, or the community. Include any awards or recognition you've received.
- Types of scholarships.** You may apply for a Bogart HOPE scholarship for:
 - College or university
 - Vocational training
 - Continuing education (life-long learner) courses
- Reference letters.** Include 3 reference letters. Each individual who writes a reference letter for you must also complete the Letter of Reference form. The form and the letter should be placed in a sealed envelope with your name on the outside and their signature across the seal. Send in the envelopes with your completed scholarship application.
 - One form and letter must be from a member of your treatment team or current health care provider (doctor, nurse, psychologist, social worker).
 - One form and letter must be from one of your teachers.
 - One form and letter must be from an adult who is not a relative.
- "Authorization to Use and Disclose Health Information for Communications or Media Activity" Form**
 - Fill out your name and date of birth, and check all boxes to which you agree on page 1
 - Signed by applicant if over 18 years old or
 - Signed by parent/guardian if applicant is under 18 years old
- Transcript of grades.** If you are applying for a college or vocational training scholarship, you must include a copy of your transcript(s) of permanent record showing your final grades for all classes taken from high school to present and Grade Point Average (GPA).
- Photograph of yourself** Send a digital photo to Carey Numoto at cnumoto@chla.usc.edu or schedule a time to have your picture taken at the HOPE Resource Center (323-361-2508)

Preparing your application package. The application package needs to be complete and submitted together (with the exception of the digital photo).

Deadline. Your application package needs to be received no later than **Friday, April 1, 2011** to be considered. Scholarships will be awarded at the Celebrate Life with HOPE event on June 5, 2011.

Send to:

Carey Numoto
HOPE Program, MS#54
Childrens Center for Cancer & Blood Diseases
Childrens Hospital Los Angeles
4650 Sunset Blvd. Los Angeles, CA 90027
PHONE: 323-361-4135 FAX: 323-361-7128

Bogart HOPE Scholarship 2011 - Application Form

A. Applicant Information

Last Name		
First Name	Middle Initial	
Home Phone	Email	
Contact Number (Different from Home #)		
Address		
City	State	Zip
Date of Birth		
Social Security Number		
Cancer Diagnosis	Treatment dates	
High School Name /Dates Attended		
Current School (if different from above)		
Current School Address		
How did you learn about the Bogart HOPE scholarship?		
Which type of scholarship are you applying for? <input type="checkbox"/> College or university <input type="checkbox"/> Vocational school <input type="checkbox"/> Continuing education (life-long learner) courses		

Tell us about your plans.

Name of school you plan to attend: _____

Are you currently accepted for admission? _____ Yes _____ No

If not, when do you expect to be notified of acceptance? _____

In what area of study will you be enrolled? _____

B. Reference Letters.

Please provide the contact information for the individuals who are writing letters in support of your application.

- Member of your cancer treatment team
Name _____
Title _____
Phone Number _____ Fax Number _____

- Teacher
Name _____
Title _____
Phone Number _____ Fax Number _____

- Other Adult
Name _____
Title _____
Phone Number _____ Fax Number _____

Volunteering.

Scholarship recipients are required to serve a minimum of 12 hours with the HOPE program. Opportunities include: (Please check all volunteer choices that interest you)

- Serving as a HOPE Program spokesperson
- Participating in fundraising/awareness events such as Celebrate Life
- Serving on the scholarship committee
- Helping with HOPE Program office tasks

Signature(s).

The information on this form and in my application package is true and correct to the best of my knowledge.

Applicant's signature

Date

Parent/Guardian's name if applicant is under 18 (Please print)

Daytime phone

Parent/Guardian's signature if applicant is under 18

Date



Bogart HOPE Scholarship 2011 - Letter of Reference Form

Applicant Information (to be completed by the applicant)

Last Name _____

First Name _____

Contact Phone _____

Applicants: Photocopy this 2 page form and give one to each letter writer.

Letter Writers:

Please complete this form along with answers to the reference questions, and give them to the applicant in a sealed envelope with your signature across the seal. The name of the applicant should be written on the envelope.

This letter of recommendation is from: (to be completed by letter writer)

_____ Treatment team member _____ Teacher _____ Other adult

Letter writer name _____

Title _____

Affiliation (hospital, school, other) _____

Phone _____

Fax (if available) _____ Email (if available) _____

Applicant ratings (to be completed by letter writer)

Criteria	1 (weak)	2 (average)	3 (excellent)	4 (outstanding)	Unable to evaluate
Motivation					
Academic potential					
Creativity					
Self discipline					
Perseverance					
Leadership					
Initiative					
Ability to overcome obstacles					
Oral communication					
Written communication					
Independence					
Problem solving					
Critical thinking					
Overall impression					

Reference questions (to be completed on a separate page by letter writer)

- ❑ How long have you known the applicant?
- ❑ In what capacity?
- ❑ What is your general impression of the applicant?
- ❑ Based on your knowledge of the applicant, is he/she prepared to succeed in the course of study the applicant desires a scholarship for?
 - In a college or university setting
 - In vocational school
 - In continuing education (life-long learner)

Please explain why.

The Bogart HOPE Scholarship is funded by a generous grant from the Bogart Pediatric Cancer Research Program and Fred Kunik and Susan Greenberg Kunik and Western Union. For more information please visit our website at www.chla.org/HOPE or contact the HOPE Program at 323-361-4135. Thank you.

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION FOR COMMUNICATIONS OR MEDIA ACTIVITY

Patient name (please print): _____

MR# (if known): _____ Patient's date of birth: _____

We understand that information about you and your health is personal and we are committed to protecting the privacy of that information. Given this commitment, we seek to obtain your written authorization before we use or disclose your health information for the purposes described below. This form provides that authorization and helps us make sure you are properly informed of how this information will be used or disclosed. Please read the information below carefully before signing this form. All references to "you" in this form are to a patient of Children's Hospital Los Angeles or, if applicable, the patient's legal representative.

Who will disclose the information? Our staff members, volunteers, and employees may disclose your health information.

Who will receive the information? Your health information may be received by authorized vendors of Children's Hospital Los Angeles and may be disclosed to the public for the purposes specified in this form.

What information will be used and disclosed? Your health information includes your visual and audio likeness on any media, quotations, contact and demographic information, diagnosis, disease, doctor's name, treatment, and treatment area.

What is the purpose of the use and disclosure? Your health information may be used and disclosed for the following Children's Hospital Los Angeles communications or media activities.

You agree to participate in an interview, to provide facts about your care and treatment, and to have photographs, audio, video, or film recordings made of you for **(check all boxes to which you agree)**:

- Advertising in print, radio, television, online, or film
- News media (print, broadcast, and online)
- Printed publications by the hospital including brochures, newsletters, direct mail, and solicitations for support
- Presentations at meetings or events (whether patient is present or not)
- Electronic communications including Children's Hospital Los Angeles' websites, official web presences, and e-newsletters
- Social networking sites (such as Facebook, Twitter, YouTube, blogs, etc.)
- DVDs or CD-ROMs
- Third-party websites, publications, or presentations produced by individuals or organizations raising awareness or funds for Children's Hospital Los Angeles
- Other: _____

May I revoke this authorization? You may revoke this authorization at any time by delivering a written and signed letter to: Health Information Management, Children's Hospital Los Angeles, 4650 Sunset Blvd., MS #46, Los Angeles, California 90027.

When will this authorization expire? This authorization will expire on December 31, 2030. Upon expiration of this authorization, Children's Hospital Los Angeles will not permit further release of any of your health information, but will not be able to retrieve any of your health information already released. When health information is disclosed to people or entities that are not required to abide by federal or state medical privacy laws, those people or entities may re-disclose such information to others and use it without being subject to penalties under those laws.

You will not be paid for your health information. Children's Hospital Los Angeles will not be paid for the use and disclosure of your health information.

You have a right to refuse to sign this authorization. Your ability to obtain treatment, payment, enrollment in a health plan, or eligibility of benefits will not be affected if you do not sign this form.

You acknowledge that you have received a copy of this form as signed by you. You also understand that you may inspect or obtain a copy of your health information.

By signing this authorization form, you acknowledge that you have read and accept all of these terms. If you are signing as a patient's legal representative, you also acknowledge that you are authorized to act on behalf of the patient.

Date: _____ Time: _____ AM/PM

Signature: _____
(patient (if 18 years or older) or patient's legal representative)

Print name: _____
(patient (if 18 years or older) or patient's legal representative)

Indicate relationship to patient:

Self

Parent

Other legal representative (describe your authority to act on behalf of the patient)

Witness signature: _____

Date: _____ Time: _____ AM/PM

Print name of witness: _____

AUTORIZACIÓN PARA USAR Y DIVULGAR INFORMACIÓN DE SALUD PARA COMUNICACIONES O ACTIVIDADES DE LOS MEDIOS DE DIFUSIÓN

Nombre del paciente (letra de molde) _____

MR# (si se sabe) _____ Fecha de nacimiento del paciente: _____

Entendemos que la información sobre usted y su salud es personal y tenemos el compromiso de proteger la privacidad de esa información. Con este compromiso, buscamos obtener su autorización por escrito antes de usar o divulgar su información de salud para los fines descritos adelante. Esta forma proporciona esa autorización y nos ayuda a asegurar que usted está adecuadamente informado de cómo su información será usada o divulgada. Por favor, lea cuidadosamente la información antes de firmar este formulario. Todas las referencias a “usted” en este formulario son para un paciente del Hospital de Niños de Los Ángeles y, si aplica, al representante legal del paciente.

¿A quién le vamos a entregar la información? Los miembros de nuestro personal, voluntarios y empleados pueden divulgar su información de salud.

¿Quién va a recibir la información? Su información de salud puede ser recibida por los agentes vendedores autorizados del Hospital de Niños de Los Ángeles y puede ser divulgada al público, para los fines especificados en este formulario.

¿Cuál información será usada y divulgada? Su información de salud incluye su información sobre su aspecto visual y auditivo en cualquier medio, citas, contactos, demografía, diagnóstico, enfermedad, nombre del médico, tratamiento y área de tratamiento.

¿Cuál es el propósito del uso y divulgación? Su información de salud puede ser usada y divulgada para las siguientes comunicaciones o actividades de publicidad del Hospital de Niños de Los Ángeles.

Usted está de acuerdo en participar en una entrevista, proporcionar hechos sobre su atención médica y tratamiento y tomar fotografías o grabaciones de audio, vídeo o películas para (marque las casillas en las que está de acuerdo)

- Publicidad en medios impresos, radio, televisión, Internet o películas
- Medios de noticias (impresos, por radio y TV, e Internet)
- Publicaciones impresas por el hospital incluyendo folletos, boletines, correo directo y solicitudes de apoyo.
- Presentaciones en conferencias y eventos (estando o no el paciente presente)
- Comunicaciones electrónicas incluyendo los sitios de Internet del Hospital de Niños de Los Ángeles, presencia oficial en Internet y boletines electrónicos.
- Los sitios de redes sociales (como Facebook, Twitter, YouTube, blogs, etc.)
- DVDs o CDs
- Sitios de terceros, publicaciones o presentaciones producidas por individuos u organizaciones que despiertan la conciencia o recaudan fondos para el Hospital de Niños de Los Ángeles.
- Otros: _____

¿Puedo revocar esta autorización? Usted puede revocar esta autorización en cualquier tiempo mandando una carta firmada a: Health Information Management, Childrens Hospital Los Angeles, 4650 Sunset Blvd., MS #46, Los Angeles, California 90027.

¿Cuándo expira esta autorización? Esta autorización caduca el 31 de diciembre de 2030. Al expirar esta autorización, el Hospital de Niños de Los Ángeles no va a permitir una mayor divulgación de nada de su información de salud, pero no estará en capacidad de recoger su información de salud que ya fue divulgada. Cuando la información de salud es divulgada las personas o entidades a las que no se les obliga a cumplir con las leyes de privacidad, esas personas o entidades pueden re-divulgar esa información a otras personas y usarla sin estar sujetas a penalidades por esas leyes.

No se le pagará por su información de salud. El Hospital de Niños de Los Ángeles no será pagado por el uso y divulgación de su información de salud.

Usted tiene el derecho de negarse a firmar esta autorización. Su capacidad para obtener tratamiento, pago, inscripción en un plan de salud o goce de beneficios no se verán afectados si usted no firma este formulario.

Usted reconoce que ha recibido una copia de este formulario firmado por usted. Usted también entiende que puede inspeccionar u obtener una copia de su información de salud.

Al firmar este formulario de autorización, usted reconoce que ha leído y aceptado todos estos términos. Si usted firma como un representante legal del paciente, también reconoce que usted está autorizado a actuar en nombre del paciente.

Fecha _____ Hora: _____ AM/PM

Firma: _____
Paciente (si tiene 18 años o más) o representante legal del paciente

Nombre en letra de molde: _____
Paciente (si tiene 18 años o más) o representante legal del paciente

Indique la relación con el paciente:

Usted mismo Padre Otro representante legal (describa su Autorización para actuar en nombre del paciente)

Firma del testigo _____

Fecha _____ Hora: _____ AM/PM

Nombre del testigo en letra de molde: _____