Scholarship Trust for the Hearing Impaired
2041 EXCHANGE DRIVE ● SAINT CHARLES, MISSOURI 63303-5987
Phone (636) 724-2227 FAX (636) 724-2457
www.tpahq.org ● support@tpahq.org

GENERAL GUIDELINES

OF

THE SCHOLARSHIP TRUST FOR THE HEARING IMPAIRED

The Scholarship Trust for the Hearing Impaired ("Trust") is recognized by the Internal Revenue Service as tax-exempt under Section 501(c)(3) of the Internal Revenue Code. As such, the Trust must comply with all rules regarding the issuance of scholarships by Section 501(c)(3) organizations.

The charitable objects and purposes of this Trust are the provision of financial aid including scholarships to citizens of the United States possessions, who suffer deafness or hearing impairment; who will benefit from medical, mechanical, specialized treatment or specialized education and who are unable to provide the funds therefore themselves.

The funds necessary to offer such scholarships and aid shall be obtained from tax deductible gifts, bequests and devises obtained from individuals, firms, trusts, corporations, other entities and from accretions of investments to the Trust funds.

Applications for charitable assistance must be submitted on the approved Trust application form by adults or if a minor, by the person having legal custody of such minor.

Trust applications shall be submitted to the Board of Trustees. The selection of recipients of Trust assistance including scholarships and the amount thereof shall be within the sole discretion of the Board of Trustees or the Trust Executive Committee.

The selection and amount of financial aid shall be granted only upon concurrence of a majority of the full Board of Trustees or full Trust Executive Committee.

In all cases, the Declaration of Trust and applicable Bylaws thereof shall be followed and complied with in full.

Amount of financial aid grants including scholarships generally range from $100.00 to $1,000.00.

Information on obtaining grants and scholarships can be obtained presently by mail: 2041 Exchange Drive, St. Charles, Mo 63303 or via phone 1-877-872-2638 (Toll Free).

The number of grants or scholarships and the amount of such grants or scholarships is determined based on available funds as determined by the Board of Trustees and the Trust Executive Committee. Recipients who obtain a grant or scholarship will be required to complete and provide the Acknowledgment Form with applicable supporting documentation.

No relatives of members of the Trust's Board of Trustees or Executive Committee, are eligible to receive grants or scholarships. Members or relatives of members of the Travelers Protective Association of America are eligible.

All applicants must attach a copy of their most recent Federal income tax return to the application.

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Full Name of Applicant: ____
Last First Middle

1. Residence Address: ____
Street City State Zip

2. Birth Date: ______________________ Place of Birth: ______________________

Telephone Number: ____

If Applicant Is A Minor

Name of Parent or Guardian: ____
Last First Middle

3. Address: ____
Street City State Zip

4. If Guardian, Type of Guardian: Natural Parent ___________ Court Appointed ___________

5. Occupation of Applicant: ____

If a Minor, Applicant's Parents Occupation: ______________________________

6. Name of Employer: ____

7. Annual Income from Employment: ______________________________________

8. Annual Income from Other Sources: ______________________________________

Identify other sources and amounts of Income:

(a) ______________________________________ $ ______________
Amount

(b) ______________________________________ $ ______________
Amount

(c) ______________________________________ $ ______________
Amount

9. Dependents of Applicant (Give names, relationship, ages and address)

If a Minor, Applicant's Parents:

Name	Relationship	Age	Address
Name	Relationship	Age	Address
Name	Relationship	Age	Address
Name	Relationship	Age	Address

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10. **School Information**

    School applicant attending: ______________________________

    Grade: __________ Public: ______________ Private: ______________

    Approximate tuition costs annually: ______________________________

    Financial assistance from other sources: ______________________________

11. What insurance does applicant have: (Include only major medical, medical pay and Blue Cross - Blue Shield)

    (a) ______________________________
    Name of Company Type of Coverage

    (b) ______________________________
    Name of Company Type of Coverage

    (c) ______________________________
    Name of Company Type of Coverage

    (d) ______________________________
    Name of Company Type of Coverage

12. Describe hearing defect in detail: ______________________________

13. Date of onset of defect: ______________________________

14. Prior medical treatment (give names and address of doctors):

    ____

15. Intended use of grant and anticipated costs: ______________________________

    ____

    ____

16. Is the Applicant related or in any way affiliated with a member of the Trust's Board of Directors, Executive Committee, an officer, or a substantial contributor? If so, explain: ______________________________

17. Remarks:______________________________

Date: ______________________ ______________________
Signature of Applicant-Parent/Guardian

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FULL RELEASE

In consideration of the furtherance of the purposes, objectives and work of the Scholarship Trust for the Hearing Impaired, I/We ___________________________ and ___________________________

___________________________ an individual/parents/guardian of a minor ___________________________

hereby grant permission to the Scholarship Trust for the Hearing Impaired, 2041 Exchange Drive, St. Charles, Missouri 63303-5987, its Trustees and employees, to take photographs and/or video tapes of said individual/minor child. I/We hereby authorize the exhibition, reproducing, publishing, televising and use of these photographs and/or video tapes for educational, information, and advertising purposes, including, but not by way of limitation, publication in the Travelers Magazine and use of said individual/minor's name and address in conjunction therewith.

In our/my own behalf, and in behalf of ___________________________

I/We hereby relinquish all right, title and/or interest that I/We may have to such video tapes, finished pictures, negatives, reproductions and copies of the original prints and negatives, and further grant unto The Scholarship Trust for the Hearing Impaired the right to exhibit, assign and transfer in whole or in part, said video tapes, negatives, original prints, and copies, or facsimiles thereof.

We also agree that no later than ninety (90) days in which a grant or scholarship is made, we will complete an Acknowledgment Form demonstrating the uses to which such grant or scholarship were put. We understand that the failure to timely return such Acknowledgment Form may subject us to sanctions, including return of all scholarship and grant funds received and/or loss of eligibility for future scholarship and grants from the Scholarship Trust for the Hearing Impaired.

This instrument shall be binding upon the undersigned, and the undersigned's heirs, executors, administrators, successors and assigns.

Executed this __________ day of __________, 20__________.

____
Signature of Individual/Parent/Guardian

______________________________________ ______________________________________
Witness Signature

NOTE

Please include Face Portrait of Applicant ONLY with this form.

MA Revised 1.26.15

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MEDICAL AUTHORIZATION

Date ______________________________

TO WHOM IT MAY CONCERN:

I hereby request and authorize you to furnish the Scholarship Trust for the Hearing Impaired, or its representative, any and all information you may have concerning the undersigned recipient with respect to any hearing defect, illness or injury, medical history, consultation, prescription or treatment, including x-ray plates and copies of all hospital or medical records.

Parent/Guardian (print name):
____

Signed: ______________________________
Address: ______________________________
____

A copy of this Medical Authorization shall be considered as effective and valid as the original.

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2041 Exchange Drive, Saint Charles, Missouri 63303

MEDICAL CERTIFICATION

Medical Certification **must be completed and signed** by Physician or Audiologist.

1. Name of Patient: ______________________________
2. Diagnosis of Hearing Defect: ______________________________

2.a. Degree of Loss: ____________ Right Db. ____________ Left Db. ________

3. Date of Diagnosis: ______________________________
4. Medical Recommendation for Future Treatment: ______________________________
5. Estimated Cost of Recommended Treatment: $______________________________

   Mechanical or Electronic Devices: $______________________________
6. Prognosis for Cure or Improvement with Treatment: ______________________________
7. To the best of your knowledge, is patient able to supply costs of recommended future treatment?

   Yes: __________ No: __________
8. If medical treatment and/or mechanical or electronic aids will not benefit patient, is specialized education or training recommended? Yes: _____ No: _____

   If yes, describe type and place of education or training: ______________________________
9. Remarks: ______________________________

Date: ______________________________

____
Signature of Physician/Audiologist

____
Street Address