Shirlock Foundation

2012 Shirlock Foundation Sara Keene Memorial Scholarship Application

The Shirlock Foundation is proud to offer the Sara Keene Memorial Scholarship to support college students battling leukemia. Named in honor of two Georgia Tech students that bravely fought but ultimately lost their battles with leukemia while also working towards their collegiate degrees, Jonathan Shirlock and Sara Keene, the Shirlock Foundation Sara Keene Memorial Scholarship aids students and their families in covering the everyday expenses that accumulate as a result of leukemia diagnosis and treatment, such as medical bills, travel costs, food and lodging. The goal of the Foundation and this scholarship is to help these families monetarily, so that they can focus their efforts on supporting their loved ones.

In order to apply for this scholarship, please fill out the below information. We also ask for a letter of recommendation from a teacher, counselor, employer or other non-family member of your choice, and for verification of your diagnosis and treatment by your physician.

Once you have completed all sections, your application will be submitted for review.

We wish you the best of health and recovery in your fight against leukemia, and hope that we can support you and your family during this time.

Sincerely,

The Shirlock Foundation Board

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www.shirlock.org

For Section 1, you will need to complete a personal information and education form.

For Section 2, you will need to complete a personal statement about your diagnosis and how it has affected your life.

For Section 3, you will need to ask a teacher/professor, guidance counselor, employer, religious leader, civic community leader, nurse or social worker to complete a letter of recommendation. Please carefully choose the person who will be writing your recommendation letter. Letters from family members will not be accepted.

For Section 4, you will need to complete a HIPAA health information disclosure form.

For Section 5, you will need to ask your physician to verify your diagnosis and treatment.

For Section 6, you will need to complete disclosure verification form.

P.O. Box 79225
Atlanta, GA 30357
keene.award@shirlock.org

Section 1 - Personal Information (To be filled out by the applicant)

Contact Information:
First Name:_____ Middle Initial:____ Last Name:_____
Date of Birth: / /
Home Address:_____
City:_____ State:_____ Zip Code:_____
Home Phone: ( ) - Mobile Phone: ( ) -
Email Address:_____

Parent/Gaurdian of Applicant (if under 18):
First Name:_____ Middle Initial:____ Last Name:_____
Date of Birth: / /
Home Address:_____
City:_____ State:_____ Zip Code:_____
Home Phone: ( ) - Mobile Phone: ( ) -
Email Address:_____

Secondary Contact:
First Name:_____ Last Name:_____
Home Address:_____
City:_____ State:_____ Zip Code:_____
Home Phone: ( ) - Mobile Phone: ( ) -
Email Address:_____

School Information:
College or University Attended at Time of Diagnosis:_____
Academic Status at Time of Diagnosis:_____ GPA:_____
Field of Study:_____ Current Enrollment Status:_____
Expected Graduation Date: / /

Please attache a current offical academic transcript.

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Section 2 - Personal Statement (To be filled out by the applicant)

The personal statement is your opportunity to tell us about yourself. We would like to hear about your life pre- and post-diagnosis and how you have changed as a result of this experience. We encourage you to take your time, be open and reflective. Find your individual voice and express it honestly.

We encourage you to consider the following questions when writing your statement: How has your leukemia diagnosis and experiences augmented or reinforced the principles by which you live your life? How will these experiences affect your academic goals as you complete your degree? How have you used your experiences with leukemia to give back to others? What has been the greatest hardship associated with your diagnosis and treatment? How has your diagnosis and treatment affected your extracurricular activities?

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Section 3 - Letter of Recommendation (To be filled out by the sponsor)

Dear Sponsor,

_____(Applicants Name)_____has applied for the Shirlock Foundation Sara Keene Memorial Scholarship. Part of the application process requires a letter of recommendation from a sponsor, and the applicant has selected you as that sponsor. Your cooperation in recommending this applicant is greatly appreciated.

Please consider the following questions when writing your recommendation: How long have you known the applicant and in what capacity? How has leukemia influenced the applicant's educational and/or career goals? How successful has the applicant been in dealing with his/her leukemia experience?

Thank you for your assistance. If you have any questions please feel free to contact the Shirlock Foundation at keene.award@shirlock.org.

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Section 4: Authorization for Use or Disclosure of Protected Health Information

As Required by the Health Insurance Portability and Accountability Act ("HIPAA"), 45 C.F.R. Parts 160 and 164.

This form shall authorize all physicians, hospitals, and other health care providers to permit examination of and to furnish full and complete medical and billing information requested by The Shirlock Foundation, and to any representative from said organization.

(Applicant must check one of the following):

□ I hereby authorize the release of my complete medical record. The information supplied is to include any and all medical records for any and all diagnosis and treatments I have received. I hereby authorize the release of my entire medical record, without exception. I authorize the release of all information contained in my medical record, chart, or any other documents in your possession regarding any care or services provided to me.

□ I authorize the release of my complete health record with the exception(s) of the following information:

□ Mental health records

□ Alcohol/drug abuse treatment

□ Other(s) (please specify):_____

Disclosures regarding HIPAA

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, psychological or psychiatric treatment or counseling, and treatment for alcohol and drug abuse. I specifically authorize the release of this information to my attorneys.

This information may be disclosed to and used by The Shirlock Foundation, its attorneys, agents, and employees, and all other individuals that The Shirlock Foundation deems appropriate and necessary in their judgment and discretion in order to process my application for the Sara Keene Memorial Scholarship.

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health care provider from which my records have been requested. I understand the revocation will not apply to information that has already been released in response to this authorization.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

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Section 4: Cont.

A photocopy of this Authorization and Request for Medical Records and Information shall be as effective as an originally signed document and shall serve as if it were an original signed document.

X_____

Signature of applicant/guardian/personal representative Date: / /

_____

Print name of applicant or personal representative and relationship to applicant

If signed by personal representative, please provide a copy of Power of Attorney or other documentation evidencing representation of the applicant/patient.

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Section 5 - Physician Verification (To be filled out by the physician)

Dear Doctor,

_____(Applicants Name)_____has applied for the Shirlock Foundation Sara Keene Memorial Scholarship. We greatly appreciate your cooperation in the verification of this patient's leukemia diagnosis using the form below. Submission of this form is required as part of the application process. Although it is not a requirement, you are welcome to attache an additional information or documentation that will help The Shirlock Foundation understand the applicant's diagnosis.

Thank you for your assistance. If you have any questions please feel free to contact the Shirlock Foundation at keene.award@shirlock.org.

Patient's Full Name:_____
Diagnosis:_____
_____
_____
_____
Date of Diagnosis: / /
Applicant's Age at Diagnosis:_____
Status of Treatment:_____
_____
_____
Additional Information:_____
_____
_____
_____
_____
Hospital / Oncology Practice:_____
Physician's Name:_____
Address:_____
City:_____State:_____Zip Code:_____
Phone: ( ) -

X_____
Signature of Physician Date: / /

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Section 6 - Disclosure Statement:

I, (Applicants Name) hereby solemnly affirm and attest that all statements and information provided by myself in the above application are true and accurate. I understand that if I have not been truthful in providing information during any aspect of this application process, I will be immediately disqualified and/or become ineligible for The Shirlock Foundation Sara Keene Memorial Scholarship, and any funds I have been awarded, or have been scheduled to be awarded, will be terminated. Furthermore, I may be subject to criminal prosecution if it is determined that I have submitted false, misleading, or fraudulent information in order to obtain or attempt to obtain this scholarship award. I understand that awards are based on information contained in the application materials provided and that submitting an application is not a guarantee that I will be awarded any scholarship funding.

I understand that the Sara Keene Memorial Scholarship award is contingent on fulfilling all of the application requirements as provided by The Shirlock Foundation.

X_____

Signature of applicant/guardian/personal representative Date: / /

_____

Print name of applicant or personal representative and relationship to applicant

If signed by personal representative, please provide a copy of Power of Attorney or other documentation evidencing representation of the applicant/patient.

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