HEMOPHILIA FOUNDATION OF MINNESOTA/DAKOTAS

750 South Plaza Drive, Suite 207
Mendota Heights, MN 55120
www.hfmd.org

651-406-8655
Fax: 651-406-8656
info@hfmd.org



# Hemophilia Foundation of Minnesota / Dakotas
# 2024-2025 SCHOLARSHIP APPLICATION INSTRUCTIONS

## Requirements of Scholarship Applicants

- Must be a person with an inherited bleeding disorder.
- Must be a patient of one of HFMD's affiliated Hemophilia Treatment Centers in Minnesota or South Dakota.
- Must use the HFMD Scholarship to pursue a course of post-secondary education.
- Completed scholarship application, letters of recommendation, and transcripts must be received by HFMD **no later than June l, 2024** to be considered for the following academic year. It is the applicant's responsibility to assure all forms are received at HFMD by June 1, 2024.
- Incomplete applications could result in disqualification from scholarship program.

## 3 Letters of Recommendation (Required)

A letter of recommendation form is attached for your use. **Please make three (3) copies of the form** and complete the information at the top of each form. The individuals providing the letters of recommendation should sign the form, attach it to the letter of recommendation, and mail it directly to the HFMD office. HFMD must receive three (3) letters of recommendation (two from previous or current academic advisors or instructors and one from a friend, volunteer supervisor, or co-worker) by **June 1, 2024.**
***Letters of recommendation will NOT be accepted from relatives or HFMD Program Committee members.***

## Transcript Request Form (Required)

A transcript request form is attached. Please use this form to request that your college or high school send a copy of your transcript.

## Selection Process

The HFMD Scholarship Committee will review scholarship applications. The HFMD Board of Directors will approve the Scholarship Committee Recommendations. *Applicants will be notified of scholarship awards by June 30th, 2024.*

## Fund Distribution

**Payments will be made directly to the academic institution.** It is very important to provide the complete address on your Scholarship Application Form for the Financial Aid Office of the school you are attending.

Please direct any questions to the HFMD office.

# Hemophilia Foundation of Minnesota / Dakotas
# 2024-2025 SCHOLARSHIP APPLICATION

## *I.* Identification Information *(Please print clearly)*

1. Name: _____
2. Address: _____
3. City: _____ State: _____ Zip: _____
4. Daytime Telephone Number: _____
5. E-mail Address: _____
6. Date of Birth: _____
7. Have you ever received a HFMD Scholarship Before? (*Check one):* _____ YES _____NO

   If yes, when: _____
8. What is your bleeding disorder/diagnosis? _____

   Which Hemophilia Treatment Center do you attend? ***(Required)*** _____
9. Are you okay with your name being published in the *Veinline*, our quarterly newsletter?

   _____ YES _____NO

## II. Educational and Employment Information

10. Field of major interest: _____
11. Are you currently enrolled in an institution of higher learning?

    _____ YES _____ NO

    if yes, **Name of institution**: _____

    **Correct mailing address**: _____

    _____

**Last 4 digits SSN or Student ID Number** ***(Required)*** _____

12. Name of institution you plan to attend: _____

    Address of Financial Aid Office for this school: _____

    _____
13. Have you submitted your application for admission? _____ YES _____ NO
14. Have you been granted admission? _____ YES _____ NO

15. Degree for which you expect to work: _____

16. Description of program of studies planned: _____

_____

_____

17. Position or profession for which you are preparing: _____

_____

18. List, in order, all institutions from which you have received credit. Please include resident study, extension, correspondence, and summer terms.

| Institution | Major field of Interest | Dates Attended | Diploma/Degree (if any) |
|---|---|---|---|
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19. Describe extracurricular activities (e.g. student council member, music, sports, honor society, school paper, school clubs, religious group, etc.)

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20. Describe outstanding achievements and awards.

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21. Describe employed and volunteer positions that you have held for more than one year.

Employed Positions:

Volunteer Positions:

## III. Financial Information

22. Describe, below, the need for financial assistance to continue your education. Please outline your anticipated expenses and income for the coming year, as well as sources of financial assistance to which you applied.

23. Please provide, below, additional information that will enable the Program Committee to better evaluate your application. Be sure to include what you hope to gain from furthering your education. Also explain any academic problems (such as a withdrawal due to bleeding disorder complications).

## IV. Declaration of Applicant

I certify that:

a) the information I have submitted is true and accurate to the best of my knowledge, and b) I understand that any untrue information will disqualify my application from any consideration for a scholarship.

_____ _____

Signature of Applicant Date

## Hemophilia Foundation of Minnesota/Dakotas

# SCHOLARSHIP APPLICATION
# Letter of Recommendation

**As part of the selection criteria, three (3) letters of recommendation MUST be received by June 1, 2024.**

Scholarship Program
Hemophilia Foundation of Minnesota/Dakotas
750 South Plaza Drive, Suite 207
Mendota Heights, MN 55120

Name of HFMD Scholarship Applicant: _____

Name of Person submitting recommendation_____

Address: _____

City: _____ State: _____ Zip: _____

Daytime Telephone Number: _____

Relationship to Applicant: _____

_____ _____
Signature of Person Submitting Recommendation Date

*****Note to the Applicant: Please make 3 copies of this form and include 1 with each recommendation letter. *****

## Hemophilia Foundation of Minnesota / Dakotas

# SCHOLARSHIP APPLICATION
# Transcript Request Form

**As part of the criteria for applying for a scholarship, an academic transcript MUST be received no later than June 1, 2024.**

I am applying for a post-secondary scholarship with the Hemophilia Foundation of Minnesota/Dakotas and in order to meet all of the requirements, I am requesting a copy of my transcript be sent to:

Scholarship Program
Hemophilia Foundation of Minnesota/Dakotas
750 South Plaza Drive, Suite 207
Mendota Heights, MN 55120

Name of Student: _____

Address: _____

City, State & Zip: _____

Telephone Number: _____

_____ _____
Signature of Applicant/Parent/Guardian Date