Scholarship Trust FOR THE Hearing Impaired
SPONSORED BY tpa

Phone 636.724.2227 ● Fax 636.724.2457
support@tpahq.org ● www.STGRANTS.org

2041 Exchange Drive
Saint Charles, Missouri 63303-5987

GENERAL GUIDELINES
OF
THE TPA SCHOLARSHIP TRUST FOR THE HEARING IMPAIRED

The TPA 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, via phone at 1-877-872-2638 (Toll Free) or online at www.STGRANTS.org.

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.
(Social Security Income Verification is Acceptable.)

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1. Full Name of Applicant: _____
   Last First Middle

2. Residence Address: _____
   Street City State Zip

3. Birth Date: _____ Place of Birth: _____

   a. Email: _____ Phone Number: _____

If Applicant Is A Minor

Name of Parent or Guardian: _____
Last First Middle

Address: _____
Street City State Zip

If Guardian, Type of Guardian: Natural Parent: _____ Court Appointed: _____

4. Occupation of Applicant: _____

   a. If a Minor, Applicant's Parents Occupation: _____

5. Name of Employer: _____

6. Annual Income from Employment: _____

7. Identify other sources and amounts of Income:

   a. _____ $_____ Amount
   b. _____ $_____ Amount
   c. _____ $_____ Amount

8. Dependents of Applicant **(If applicant is a minor: list parents and siblings of applicant in the home.)**

Name	Relationship	Age
Name	Relationship	Age
Name	Relationship	Age
Name	Relationship	Age

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9. Have you applied for this scholarship in the past? **Yes:** ☐ **No:** ☐

   a. If yes, were you approved for a grant? **Yes:** ☐ **No:** ☐

   b. If you were approved, list the amount awarded and the use for the previous grant(s):

Year	Amount	Previous Use
_____	$_____	_____
_____	$_____	_____
_____	$_____	_____
_____	$_____	_____

   c. If you were denied for a previous grant, please explain why: _____

_____

_____

_____

10. What insurance does applicant have: (Include only major medical coverage and medical pay)

   a. _____
   Name of Company Type of Coverage

   b. _____
   Name of Company Type of Coverage

11. Describe hearing deficiency in detail: _____

_____

_____

12. Date of onset of deficiency: _____

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

_____

_____

14. Intended use of grant and anticipated costs (be specific): _____

_____

_____

_____

_____

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(Only fill out this box if intended use is for specialized schooling)

School applicant is attending: _____

Grade:_____ Private: ☐ Public: ☐

Approximate tuition costs annually: _____

Financial assistance from other sources: _____

_____

15. 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: _____

_____

16. 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 _____

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 _____, _____.

_____
Signature of Individual/Parent/Guardian

_____ _____
Print Witness Name Signature of Witness

Please include Portrait Photo of Applicant ONLY.

Publicity: ☐ No Publicity: ☐

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MEDICAL AUTHORIZATION

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

Applicant or Parent/Guardian if minor (print name)	Signature of Applicant or Parent/Guardian
Date	Street Address

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MEDICAL CERTIFICATION

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

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: $ _____
   a. 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:
9. If yes, describe type and place of education or training: _____
10. Remarks: _____
    _____

Date	Signature of Physician/Audiologist **(ONLY)**
Contact Phone Number	Street Address

8

All questions are required to be answered for consideration of grant. Missing information will delay processing of application.