Via Cognitive Health
FY25 Scholarship Application

BEFORE COMPLETING APPLICATION PLEASE READ CAREFULLY:

- Via Cognitive Health scholarships are awarded without regard to race, color, religion, sex or age.
- Via Cognitive Health selects scholarships recipients based on need.
- All scholarship recipients must have a care partner.
- All applications will be kept on file for one year.

ANSWER ALL QUESTIONS IN THIS APPLICATION FORM. INCOMPLETE APPLICATIONS CAN NOT BE CONSIDERED.

General Information about the Client

Date: _____

Client's Name: _____

Address: _____

_____County_____

Telephone Number: _____ Date of Birth_____

Diagnosis: _____

Length of Illness: _____

General Information About the Caregiver

Caregiver's Name: _____

Address: _____

_____County_____

Home Phone Number: _____Work Phone Number: _____

Cell Phone Number: _____ Email: _____

Date of Birth: _____Relationship to Client: _____

Household Income

Please provide proof of income for the person whom the scholarship is for and if married both potential client and spouse, bank statement, social security income letter, W-2, or paycheck stub.

Please check the source of income for the Client whom the scholarship application is for:

____ Employment ____ Social Security ____ VA ____ Work Related Pensions

____ Bank interest, retirement accounts, rental property, investments, etc.

What category best describes the yearly income of the Client:

_____$43,741

_____$36,451 - $43,740

_____$29,161 - $36,450

_____$20,871 - $29,160

_____$0 - $21,870

What category describes the yearly income of all other adults in the household:

_____$43,741

_____$36,451 - $43,740

_____$29,161 - $36,450

_____$20,871 - $29,160

_____$0 - $21,870

Please list any costs related to your loved one that she/he must pay for each month.

	Item	Approximate Cost
Household	Mortgage/rent	
	Electricity	
	Gas	
	Water	
	Alarm/security system	
	Garden services	
	Cleaning services	
	Other	
Insurance	Car	
	Life	
	Household	
	Health	
	Other	
Loans & Credit	Car	
	Credit card	
	Other	
Savings	Personal	
	Retirement	
	Holiday	
	Other	
Other	Cell & telephone	
	Internet	
	TV Cable/Netflix or similar	
	Other	
Health	Medical Bills/CoPays	
	Prescriptions	
	Home Health Aide	
	Other (Depends, etc.)	

Please use this section to give insight into your loved one's circumstances.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature: _____ Date: _____

Print Name: _____

Telephone Number: _____

Please email your completed application and proof of income to kim@viacognitivehealth.org.