VOCATIONAL SCHOLARSHIP APPLICATION

LEE HENDERSON MEMORIAL SCHOLARSHIP FUND

Job Skill Training, Certification Programs, and Trade Schools

INSTRUCTIONS AND DETAILS

Who can apply?

Current participants in the Ag Health Benefits group health benefit program can apply. Legal spouses of plan participants as well as children and grandchildren under age 25 can also apply. Children and grandchildren do not need to live with the plan participant.

Vocational scholarships are for:

- Those who wish to build job skills or learn a new trade;
- Aspiring students who are not yet in school;
- Current full- or part-time students at any vocational, educational, or job training program in California; and,
- Certificate programs including those at local community colleges in California.

Several scholarships will be awarded in amounts up to $5,000 each.

Scholarships can be used for enrollment fees, books, supplies, and other program-related expenses. Past applicants and past winners may apply for a second scholarship in another year. Applicants are eligible for up to two AHBA scholarship awards.

Vocational scholarship applications are accepted through April 15, 2024

Vocational scholarship winners will be chosen by a Selection Committee based on:

- The applicant's motivation, character, ability, and potential;
- The applicant's financial need;
- Recent personal or professional letter(s) of recommendation.

Incomplete applications will not be considered.

Program Details

Available at www.aghealthbenefits.org/scholarships

Questions? Please call (707) 963–7191 or visit our office at 5 Financial Plaza, Suite 116, Napa CA 94558.

The vocational scholarship program is named in honor of Lee Henderson who led California Winegrower Foundation from 1973–2006 and dedicated her career to the agricultural community.

Vocational Scholarship Application Instructions

VOCATIONAL SCHOLARSHIP APPLICATION

LEE HENDERSON MEMORIAL SCHOLARSHIP FUND

Job Skill Training, Certification Programs, and Trade Schools

Applicant's Name _____

Applicant's Address _____
Street City State Zip

Applicant's Email_____**Telephone Number** _____

I. Please tell us about your affiliation with AG HEALTH BENEFITS ALLIANCE:

Are you the group health plan participant? YES NO

If YES, name of your employer: _____
Health Care identification number (HCID): **W00 -** _ _ **-** _ _ _ _ *(located on your health care ID card)*

If NO, name of the participant: _____
Please circle your relationship to the participant and provide the applicable date:

Spouse	Date of Marriage_____
Child (under age 25)	Date of Birth _____
Grandchild (under age 25)	Date of Birth _____

Participant's employer: _____
Participant's Health Care identification number (HCID): **W00 -** _ _ **-** _ _ _ _ *(this number is located on the participant's health care ID card)*

II. Please tell us about yourself and your goals *(attach additional sheet if needed)***:**

1. What is your current work and/or daily experience?_____

   _____

   How long have you been in your current position? _____

   Please list any past work/life experiences that relate to the training you are interested in.

   _____

2. What kind of technical or job training would you like to receive?

   _____

   How would this training help you? _____

3. Please provide information about the school or organization providing the training:

   Name_____

   Address _____

   How is this training conducted? *(circle one)* In-person Online Combination of both

   How long would this training program take to complete?_____

4. How would the skills you gain from this training support your goals?

_____

_____

_____

_____

_____

_____

_____

_____

III. Please tell us how this scholarship will help you financially:

1. What is your anticipated cost for enrollment?_____ Related Expenses?_____ TOTAL_____
2. How many members are living in your HOUSEHOLD? Include all adults, children, and yourself: _____
3. What is the annual HOUSEHOLD income? Please include income from all sources:
   - ☐ Less than $25,000/year
   - ☐ $25,001 - $50,000/year
   - ☐ $50,000 - $75,000/year
   - ☐ $75,001 - $100,000/year
   - ☐ More than $100,000/year
4. Have you applied for or received any other funding to complete this program? YES NO
   a. If YES, please provide the source and amount granted. _____

IV. Please include at least one or professional or personal letter(s) of recommendation.

Application Deadline: April 15, 2024

Return your completed application by April 15, 2024

By email: *info@aghealthbenefits.org*

By mail: AHBAEF Scholarship Committee; 5 Financial Plaza, Suite 116; Napa, CA 94558

Scholarships will be awarded based on fair, objective, and non-discriminatory methods. Finalists will be chosen based on information provided in the written application and a virtual interview with the Selection Committee. AHBAEF will notify award recipients by mail. Scholarships will be issued upon proof of educational enrollment and acceptance of program terms.

By signing this application, I am stating that all information that I have submitted is truthful and accurate.

Signature of Applicant **Date**

If under age 18, print the name of the Parent/Guardian Approving of Application Submission

Signature of Parent/Guardian **Date**

AHBA Educational Foundation is a non-profit, 501c3 organization, tax ID #83-4433051. Thanks to Mike Wolf, the Michael L Wolf Trust, and many others for the generous donations that make this program possible.