

**A.L.S. FAMILY CHARITABLE FOUNDATION, INC. SCHOLARSHIP**  
**\$1,500**  
***Presented by the A.L.S. Family Charitable Foundation, Inc.***

Applicant must be a child (biological/adopted/step) of an A.L.S. Family Charitable Foundation patient (either living or deceased), a recent high school graduate with a 3.0 average, and a matriculated student taking at least 9 credit hours with a full-time course load preferred.

Applicant must be a legal resident of New England and attending an accredited higher educational institution. However, if the student is applying for a scholarship to attend a non-accredited school, the Board will consider your request. Award amount will be determined on a case-by-case basis.

**Please submit the following items with your application:**

- Letter of Acceptance from the College or most recent Transcripts
- Essay of approximately 500-1,000 words describing how A.L.S. has impacted your life, and what your educational and life goals are.

Due to the number of applications received, only applicants selected to receive a scholarship will be notified with a letter.

The Scholarship Committee adheres to the following procedures:

If the student does not use the awarded funds by September of the current year after receiving the scholarship, the student will automatically forfeit the award.

**Please complete the following and return with your essay.**

*(Please print clearly)*

Name: First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Are you a child of someone who had been diagnosed with Amyotrophic Lateral Sclerosis?

- YES**  
 **NO**

Have you or you parents received any type of assistance from any other A.L.S. Organization?

If so, please list which organization (s) \_\_\_\_\_

**CERTIFICATION**

Student must read and **sign below** to be eligible for consideration.

- I certify that all information provided is complete and accurate to the best of my knowledge.
- I certify that I will be full-time student for the upcoming academic year.
- I give consent to allow academic/enrollment information to be released to the appropriate parties to be used to verify eligibility for this scholarship.
- I certify that I have read this application and certification and accept all conditions.

Student's Signature \_\_\_\_\_ Date \_\_\_\_\_

**(Guardian if under 18 years of age)**

**Please Mail Application, Essay, Patient Information Form and Transcripts to:**

A.L.S. Family Charitable Foundation, Inc.  
Scholarship Committee  
P.O. Box 229  
Buzzards Bay, MA 02532  
(508) 759-9696