**VHCF PSYCH NP SCHOLARSHIP PROGRAM**

707 East Main Street, Suite 1350 • Richmond, VA 23219 • **www.vhcf.org**  
Phone: (804) 828-5804 • Fax: (804) 828-4370 • email: [info@vhcf.org](mailto:info@vhcf.org)



**Document Checklist**

This checklist is provided to facilitate the application process. Please send us all documents below in one envelope to ensure that your application is complete. Incomplete applications will not be processed. Maintain a copy of this application for your records.

* **Completed application form**
* **Applicant resume**
* **Applicant’s statement of purpose/intent**—Please provide a one-page typed document describing your interest in obtaining a PMHNP certificate and how you intend to use that credential after program completion. How will receiving this scholarship assist you in meeting your professional goals? How much of your practice has included diagnosing of treatment for behavioral health conditions? Be sure that you’ve included your name in the title of the statement.
* **Copy of letter of acceptance from PMHNP program**
* **Verification of employment in a health safety net setting & employer’s agreement to provide flexible work time OR**
* **Verification of volunteer history and commitment at Health Safety Net clinic**
* **Verification of employer’s intent to employ after PMHNP program completion**
* **Completed/signed consent to release information to VHCF** (FERPA form)
* **Completed/signed attestation form/contract**

**Print and provide original signatures on documents where it is required. Mail the completed application and all required attachments to:**

Virginia Health Care Foundation

ATTN: NP Scholarship Program Manager

707 E. Main Street, Suite 1350

Richmond, VA 23219

**For questions**, contact: Sarah Jane Stewart: [sarahjane@vhcf.org](mailto:sarahjane@vhcf.org) or #804-828-5804.

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**Application Form**

**Personal Information**

Applicant’s Full Name:

Maiden/Family or other Previous Names Used:

Home Address:

Daytime Phone: Evening Phone:

Mobile Phone:

Email Address (Work): Email Address (Home):

Date of Birth:

Place of Birth:

Are you a US Citizen?

How long have you been a resident of Virginia?

Race/Ethnicity:

Marital Status:

Do you speak a language other than English? Yes or No

If so, please list: Language: Read Write Speak Fluently

**Professional Credentials**

Please list ALL of your professional degree programs, licenses, and national certifications here, or you may include in your resume, which will be attached.

**Employment Information**

Current Place of Employment:

Executive Director’s Name:

Employer Address:

Employer Phone Number:

Employer & Executive Director Email Addresses:

Start Date of Employment:

Current Number of Hours/Week:

Anticipated Number of Hours/Week during PMHNP program:

Describe your current practice (*typical day, age range, types of patients, etc*):

Do you currently have any specialty area of expertise (*e.g., diabetes, asthma, etc.*)

Do you currently live and/or work in a federally designated medically underserved or health professional shortage area? If yes, please specify whether primary care, dental or mental health shortage area. If you don’t know, you can check here -<http://hpsafind.hrsa.gov/>

**Financial Information**

Current salary (annual):

Anticipated salary during PMHNP program (annual):

Other family income (annual):

Other sources of financial aid (scholarships, loans, etc.):

Family income from any other sources:

Value of Assets totaling more than $100,000 other than your primary residence and cars:

**I certify that all of the information provided in this application is correct and current on the date indicated below.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Applicant Signature Date Completed**