



**ELDERLY COMPASSIONATE CARE**  
*Macedonia Education Technology and Career Academy*

# Scholarship and Training Application

**PLEASE** Name \_\_\_\_\_ Social Security # (last 4 digits only) \_\_\_\_-\_\_\_\_-\_\_\_\_  
First Name Middle Initial Last Name

**PRINT** Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**E-mail** \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE \_\_\_\_\_

**Do you have a current Level 2 Background Check (within past 5 years)?**

- 1. Yes
- 2. No

**What program are you here for?**

- 1. HHA
- 2. CNA
- 3. LPN

**Are You?**

- 1. Unemployed (Not Working)
- 2. Dislocated Worker (Laid Off)
- 3. Displaced Homemaker (Loss of Income)
- 4. Minimum Wage/Incumbent Worker
- 5. SNAP, TANF or SSI Recipient
- 6. Offender/Ex-Offender
- 7. Older Worker (55 and older)
- 8. Non-English Speaking/English as a Second Language
- 9. Lack of HS Diploma or GED?
- 10. Retired
- 11. Other Disadvantaging Condition: \_\_\_\_\_
- 12. None

**Employment Goal:**

- 1. Full Time
- 2. Part Time
- 3. Temporary

**What is your training schedule preference?**

- 1. Day Schedule
- 2. Evening Schedule
- 3. Doesn't Matter

**Are you a Brevard County resident?**

- 1. Yes
- 2. No

**Work Experience:**

- 1. HHA
- 2. CNA
- 3. Phlebotomy
- 4. PCT/PCA
- 5. LPN
- 6. Customer Service
- 7. Education / Instruction / Training
- 8. Hotel and Hospitality
- 9. Dietician
- 10. Housekeeping
- 11. Activities Assistant
- 12. Other medical / healthcare jobs (List):  
\_\_\_\_\_  
\_\_\_\_\_

13. None

**Gender:**

- 1. Male
- 2. Female
- 3. Other

**Household Size (Identify Number):**

- 1. Adults \_\_\_\_\_
- 2. Children \_\_\_\_\_

**Household Annual Income (per year ) (Combined Total of all Adults Receiving or Earning Income):**

**Do you have a SSN?**

- 1. Yes
- 2. No

**Are you authorized to work in the U.S.?**

- 1. Yes
- 2. No

**Are you a Military Dependent?**

- 1. Yes
- 2. No

**Have you ever Served in the Military?**

- 1. Yes
- 2. No

**Were you Honorably Discharged if you Served in the Military?**

- 1. Yes
- 2. No
- 3. Not Applicable

**Education Level Completed:**

- 1. Elementary School
- 2. Junior High/Middle School
- 3. High School
- 4. GED
- 5. Vocational Training
- 6. 2 Year Degree (Associates)
- 7. 4 Year Degree (Bachelors)
- 8. Post Graduate

**Identify Available Transportation:**

- 1. Personal Car
- 2. Public (SCAT)
- 3. Lynx Access
- 4. Other
- 5. Bicycle
- 6. Ride from Family/Friends
- 7. None

**Have you ever been convicted of a felony or incarcerated within the past 7 years?**

- 1. Yes
- 2. No

**Do you have a Driver's License or FL ID (circle which one)?**

- 1. Yes
- 2. No

**Are you currently working?**

- 1. Yes
- 2. No

**Do you have a Disability?**

- 1. Blindness or Other Visual Impairment
- 2. Deafness or Other Hearing Impairment
- 3. Other Physical Disability
- 4. Neurological Disability
- 5. Learning Disability
- 6. Chemical Dependency
- 7. Psychiatric and/or Emotional Disability
- 8. Developmental Disability
- 9. Other Disabling Condition: \_\_\_\_\_
- 10. None

**Race:**

- 1. African-American
- 2. Asian
- 3. Bi-Racial
- 4. Caucasian
- 5. Hawaiian/Pacific Islander
- 6. Hispanic
- 7. Multi-Racial
- 8. Native American
- 9. Other

**How did you hear about us?**

- 1. Macedonia Church Contact
- 2. Goodwill Job Center
- 3. CareerSource Brevard
- 4. Friend/Family
- 5. Horizon Health Care Institute
- 6. Harris- Casel Institute
- 7. Keiser University
- 8. Community Action Agency
- 9. Facebook
- 10. Other \_\_\_\_\_

**Education:**

Type	Name and Location (City, State)	Last Year Completed	Degree	Major
Elementary School				
Middle School				
High School/GED				
College/University				
Trade School/Certifications				

**Work Experience (Current Position plus Last 2 Jobs):**

Employer	Supervisor's Name	Job Title	Date Range (From – To)	Reason for Leaving

**Emergency Contact Information:**

Name	Relationship to Applicant	Contact Number/Email address

**Identify Barriers that Could Impact Getting to Training:**

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**Disclaimer** - By signing, I hereby certify that the above information, to the best of my knowledge, is correct. I understand that falsification of this information may prevent me from receiving a scholarship for healthcare training or may lead to my dismissal from training if selected. I also provide consent for former employers to be contacted regarding work records/history.

**PLEASE SIGN:** \_\_\_\_\_

Signature

\_\_\_\_\_ Date