COOPER OPEN SCHOLARSHIP FUND

cooperopenmitoscholarship@gmail.com PO Box 71West Peterborough, NH 03468 www.COOPEROPEN.COM

Cooper open
to fight Mitochondrial Disease

When to apply?

The application deadline is July 31st. We will notify the award recipient and deliver the scholarship in person (if possible) at the Cooper Open Event, otherwise alternate arrangements can be made.

Who should apply?

- Students who have Mitochondrial Disease
- Between the ages of 17 and 26 or a graduate student.
- Enrolling full time or half time in a 2-year, 4-year or graduate degree program.

Selection criteria

Students who have Mitochondrial Disease are selected to receive awards based on financial need, academic merit and other non-academic factors such as community service, school activities and work experience. Highest priority is given to students with the fewest financial resources.

Determining financial need

Candidates are required to submit a copy of the Student Aid Report (SAR) that is the result of filling out the Free Federal Form (FAFSA), which determines what a particular family can reasonably afford for education or the expected family contribution. In addition, finalists will be asked to supply a copy of the financial aid package offered by the institution to be attended.

Award availability

This is a competitive program.

Award decisions

Applicants will be notified of their status by September and awarded in person (where possible) at the annual Cooper Open event.

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APPLICANT/BENEFICIARY of scholarship

Name (First, Middle, Last)		Street Address
Home Telephone		City/State/Zip Code
Date of Birth	Gender ☐ Male ☐ Female	Preferred Language

FAMILY INFORMATION

Parent/Guardian/Adult Applicant	**Parent/Guardian/Spouse**
Name (First and Last)	Name (First and Last)
Relationship to Applicant ☐ Self	Relationship to Applicant
Street Address	Street Address
City/State/Zip Code	City/State/Zip Code
Mailing Address (if different from Home Address)	Mailing Address (if different from Home Address)
Preferred Contact Methods and Times (*indicate all that apply*)	**Preferred Contact Methods and Times** (*indicate all that apply*)
☐ **Home Phone:**_____ Times: ☐ Mornings ☐ Afternoons ☐ Evenings	☐ **Home Phone:**_____ Times: ☐ Mornings ☐ Afternoons ☐ Evenings
☐ **Cell Phone:**_____ Times: ☐ Mornings ☐ Afternoons ☐ Evenings	☐ **Cell Phone:**_____ Times: ☐ Mornings ☐ Afternoons ☐ Evenings
☐ **Work Phone:** _____ Times: ☐ Mornings ☐ Afternoons ☐ Evenings	☐ **Work Phone:** _____ Times: ☐ Mornings ☐ Afternoons ☐ Evenings
☐ **E-mail:**_____ Times: ☐ Mornings ☐ Afternoons ☐ Evenings	☐ **E-mail:**_____ Times: ☐ Mornings ☐ Afternoons ☐ Evenings
Preferred Language	**Preferred Language**
Household Type (select one): ☐ Single-parent/guardian	☐ Two-parent/guardian

List all people who live in Applicant's home, including Parents/Guardians/Adults listed above.

Name (first and last name)	**Date of Birth** (month / day / year)	**Relationship to Applicant**

Attach another page if you need more space.

Number of Family Members affected by Mitochondrial Disease (including above Applicant/Beneficiary): _____

Number of previously approved/awarded Applications for the Cooper Open Scholarship Fund: _____

[FOR OFFICE USE ONLY: Application No._____]

PERMISSION TO SHARE INFORMATION

I understand that the information given to you will be used solely by members of the **Cooper Open Scholarship Fund Review Committee** for consideration of this Scholarship Application. I understand that all decisions of Cooper Open Scholarship Fund Review Committee are final. I also understand that I should not make financial decisions assuming that I will receive payment from the Cooper Open Scholarship Fund.

I/We give permission for the Cooper Open Scholarship Fund Review Committee to contact any provider listed on this Application in order to:

- obtain or verify any information needed to determine if Applicant is eligible for the Scholarship Fund;

Unless I/we cancel this permission, it will cover the period of time needed to process this Application. I/We understand that I/we can rescind this Application and cancel this permission at any time by writing to the Committee.

I/WE ATTEST THAT THE INFORMATION PRESENTED ON THIS APPLICATION IS TRUE AND COMPLETE.

Parent/Guardian/Adult Applicant:

_____
Signature

_____
Print Full Name

_____
Date

Parent/Guardian/Spouse:

_____
Signature

_____
Print Full Name

_____
Date

FOR DEPENDENT APPLICANTS, AGE 18 OR OLDER:*

I have read and understand the information above. I give permission to the Cooper Open Scholarship Fund Review Committee to receive and share information in the ways described above. I also give the Cooper Open Scholarship Fund Review Committee permission to share information about me with my parent(s)/guardian(s), and to receive information from my parent(s)/guardian(s) in order to determine eligibility and the amount of assistance.

_____ _____ _____
Signature of Applicant, age 18 or older *Print Full Name* *Date*

* A signature is required of all applicants age 18 or older unless they have a court-appointed guardian. If you are the court-appointed guardian for the Applicant, please provide documentation of guardianship.

Please return complete Application with requested medical & financial documentation to either option below:

scanned electronically can e-mail to:
subject: Cooper Open Scholarship Fund
cooperopenmitoscholarship@gmail.com

or paper version can be mailed to:
Cooper Open Scholarship Fund
PO Box 71 West Peterborough, NH 03468

[FOR OFFICE USE ONLY: Application No._____]

APPLICANT'S MEDICAL INFORMATION AND FUND REQUEST

Diagnoses: _____

_____

Briefly describe Applicant's condition:

_____

_____

_____

COOPER OPEN SCHOLARSHIP FUND is intended to support expenses towards higher education for an individual affected by mitochondrial disorder. Please explain your intended use of this funding, if your application is approved, including any extenuating family circumstances:

_____

_____

_____

Fund Request: Supporting Documentation

☞

Please include a letter from the Applicant's doctor confirming Applicant has or is suspected to have a Mitochondrial Disorder. This can be sent directly to the Cooper Open Scholarship Fund Review Committee or included with the application.
The attached Reference Cover Letters shall serve as an introduction for your request.

Provider	*Name and Department*	*Facility/Address*	*Phone*
Primary Care Doctor			
Mitochondrial Specialist			

Your signature on Page 2 gives the Coopen Open Scholarship Review Committee permission to contact providers listed above.

Determining financial need: Costs and Family Resources

☞

Candidates are required to submit a copy of the tuition cost and of the Student Aid Report (SAR) that is the result of filling out the Free Federal Form (FAFSA), which determines what a particular family can reasonably afford for education or the expected family contribution. In addition, finalists may be asked to supply a copy of the financial aid package offered by the institution to be attended.

Estimated Total Cost $ _____

TOTAL Available Funding $ _____

Request From the Scholarship Fund **$** _____

NOTE: Average Scholarship is between $500 - $1000

FOR OFFICE USE ONLY:
Application No._____ Date:_____

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Letter to the Physician/Community Worker

To be completed by Applicant:

Patient's Name (First, Middle, Last)	Street Address
Date of Birth	City/State/Zip Code
Telephone	

Description of the assistance for which this scholarship is being applied:

_____

_____

Signed: _____ Date: _____
(Parent/Guardian/Adult Applicant)

.....

Dear _____ ,
(Name of Provider)

Your patient/client is applying for assistance from the **Cooper Open Scholarship Fund.** Please provide a statement on hospital/agency letterhead describing how the scholarship need described above relates to his or her condition. Please include any information about the patient's situation that may be pertinent for the Cooper Open Scholarship Fund Review Committee to consider. In addition:

- ***Physicians:*** Please verify your patient's diagnosis of having mitochondrial disease or having demonstrated a strong suspicion of mitochondrial disorder.
- ***Community Workers (Social Worker, Case Manager, Clergy… etc.):*** Please describe your involvement with this patient (including length of relationship and your role in their care). Please explain your knowledge of the patient's background, living situation, and financial situation *(Please note that there is no income eligibility to apply for this scholarship)*. Please list any other resources which this family has contacted for support, to your knowledge.

Please attach this cover letter to your letter of explanation and return to Cooper Open Scholarship Fund (e-mail or address above). All communication will be kept confidential. We will acknowledge receipt of your submission to the Applicant, on your behalf. If you have any questions, please contact us via e-mail. **Thank you for your time!**

[FOR OFFICE USE ONLY: Application No._____]