NAHC/State Association
Aide-to-RN Scholarship Program

Name of State Association ____________________

Contact Person ____________________

Phone # ____________________ Email address ____________________

Name of Home Health Aide Applicant ____________________

Name of Employing Home Care or Hospice Agency ____________________

Name of Accredited School of Nursing ____________________

Address ____________________

State Association Executive Director Signature ____________________

Date ____________________

Applicant Section

I agree to the following conditions for this scholarship:

1) To attend an accredited School of Nursing;
2) To pursue employment in home care following graduation

Name ____________________ Signature ____________________

Date ____________________

Agency Section

Name ____________________

Agency Director ____________________ ____________________

Address ____________________ ____________________

Phone ____________________

Email address ____________________

NAHC Member ID number ____________________

Signature ____________________

Date ____________________