Arkansas Children's Hospital | Auxiliary

Dear Parent/Teacher:

It gives us great pleasure to inform you of a program at Arkansas Children's Hospital. The ACHiever program was initially developed for girls and has been ongoing in the community for the past 16 years. This fall the program will grow to offer a separate ACHiever boy program for young men who will be in 9th grade during the 2019-2020 school year. This program is sponsored by the hospital's Auxiliary, a group of volunteers who work to raise money and awareness for ACH.

We believe that this program is beneficial in exposing young women and men to Arkansas Children's Hospital, introducing them to a variety of wonderful medical careers, and encouraging the importance of philanthropy. ACHiever participants may earn community service hours working in non-patient care areas.

The program will meet once a month from September to April for educational sessions and there will be a handful of community service opportunities through the seven month program. Our first educational session is an orientation, with a parent, in September. **Educational sessions will take place one Monday of each month from 5:30 – 6:45 pm**. Educational sessions will include tours of Angel One Transport Department, Heart Center, Neonatal Intensive Care Unit, PULSE Center (Education Simulation Center), Child Maltreatment department and Speech, Audiology and Rehabilitation department. We conclude the program in April with a graduation dinner where ACHievers and their parents dine for a farewell celebration.

Please share this information with your daughter. If he decides to make a commitment to the ACHiever program, we ask that you **mail the enclosed application with a tax deductible deposit*.** If space is not available when your daughter's application is received, your deposit will be returned promptly. Since this is our inaugural year to offer a boy program there are limited spaces.

We are very pleased, thanks to the generosity of local businesses and individuals, to provide a limited number of scholarships based on the financial need of the applicant. Please see the enclosed additional criteria for earning a scholarship. **If you would like to apply for a scholarship we ask that you mail the enclosed scholarship application and a letter identifying financial need from you and your parent postmarked by May 30, 2019.** Acceptance for a scholarship will be based on the application and letter of recommendation with supporting documentation.

Once your daughter has been accepted as an ACHiever, you will be notified and additional detailed information will be mailed to you. Should you have any questions, please don't hesitate to call us at 501-364-4235.

Thank you,
Jamie Brainard
Director of Auxiliary Services

**Your gift is tax deductible to the fullest extent allowable by law.*

Arkansas Children's Hospital ACHiever Program

Application 2019-2020

Please enclose a photo that will be used for identification purposes only

NAME OF APPLICANT: _____

AGE_____ GRADE_____ SCHOOL ATTENDING FALL 2019:_____

HOME ADDRESS: _____CITY_____ZIP_____

PHONE: _____ APPLICANT'S E-MAIL: _____

PARENT/S NAME: _____

ADDRESS: _____

HOME PHONE: _____ CELL PHONE: _____

PARENT'S EMAIL ADDRESS_____

SPONSOR NAME (*IF OTHER THAN PARENTS*):_____

RELATIONSHIP TO APPLICANT: _____

ADDRESS: _____

BUSINESS: _____

BUSINESS ADDRESS: _____

APPLICANT'S CURRENT ACTIVITIES/INTERESTS:

_____

_____

WHY ARE YOU INTERESTED IN THE ACH ACHIEVER PROGRAM? _____

_____

_____

_____

APPLICATION MUST BE MAILED TO:

ACHiever Program, Arkansas Children's Hospital,
1 Children's Way, Slot 661, Little Rock, AR 72202

PARTICIPATION IS LIMITED. APPLICANTS ARE ACCEPTED IN THE ORDER IN WHICH APPLICATIONS WITH DEPOSITS ARE RECEIVED. IF CLASS IS FULL, DEPOSITS WILL BE RETURNED.

PAYMENT OPTIONS (CHECK ONE):

- ☐ My check for the total amount of $1,200 is enclosed.
- ☐ My check for the deposit of $200 is enclosed. Bill me remainder per payment schedule.
- ☐ Please charge $1,200 to my credit card.
- ☐ Please charge $200 to my credit card. Please bill me remainder per payment schedule.

  Check one: ☐ VISA ☐ MasterCard ☐ American Express ☐ Discover

Name as it appears on credit card: _____

Credit Card #:_____Expiration Date: _____

Please make checks payable to: Arkansas Children's Hospital Auxiliary

2019-2020 ACHiever PLEDGE SCHEDULE

The participation fee for the ACH ACHiever program is $1,200 and includes all of the activities, plus three tickets to the April 2020 graduation dinner to honor participants. Please note that this fee is **non-refundable** once the applicant has been accepted into the program. For your convenience, the following payment schedule is offered:

Due with Application…..……..…….. $200

You will be invoiced after your application is received. You may pay in installments, if you prefer.

Balance is due prior to January 2020

The above payment schedule may be followed or total payment may be made at any time. This is a tax-deductible contribution to Arkansas Children's Hospital, the only pediatric hospital in Arkansas. Since you will receive no direct benefit as a result of your gift, you may claim the full amount as a charitable deduction, according to the IRS guidelines. We accept personal or business checks, cash, VISA, MasterCard, American Express and Discover.

A child may be sponsored by a parent, relative, friend, business or civic organization. All participant fees will be used to support Arkansas Children's Hospital Auxiliary projects.

SCHOLARSHIP APPLICATION FORMS ARE DUE BY May 30, 2019

A limited number of scholarships are available for students who meet the following criteria:

1. Will be entering the ninth grade in the fall.
2. Will be unable to participate financially without a scholarship.
3. School counselor must certify that applicant maintains a grade average of B or better.
4. School counselor or current teacher must write a letter of recommendation on the school's official letterhead. Letter must be attached to scholarship application form.
5. Student must submit essay of no more than 100 words indicating why participation in the program is important to the student.
6. Scholarship finalists will be required to participate in an interview with the selection committee.

If your daughter is interested in participating and he meets the above criteria, please complete the enclosed scholarship application and attach it, along with supporting documentation, before mailing. No deposit is necessary.

Arkansas Children's Hospital ACHiever Program

Scholarship Application

NAME OF APPLICANT: _____

AGE: _____ GRADE: _____

SCHOOL ATTENDING FALL 2019:_____

HOME ADDRESS: _____CITY_____ZIP_____

APPLICANT'S PHONE: _____ APPLICANT'S E-MAIL_____

PARENT/S NAME: _____

ADDRESS: _____

PARENT'S CONTACT PHONE: _____ PARENT'S E-MAIL_____

CURRENT ACTIVITIES: _____

_____

SPECIAL INTERESTS: _____

_____

ADDITIONAL COMMENTS: _____

MAIL TO:

ACHiever Program, Arkansas Children's Hospital,
1 Children's Way, Slot 661, Little Rock, AR 72202.

NO HAND DELIVERIES. SCHOLARSHIPS ARE LIMITED. NO DEPOSIT NECESSARY.

APPLICATIONS FOR SCHOLARSHIP WILL ONLY BE CONSIDERED WITH THE FOLLOWING DOCUMENTATION COMPLETED AND ENCLOSED:

- □ I have completed and enclosed the front and back of this scholarship application.
- □ I have attached my essay.
- □ I have attached my letter of recommendation.
- □ I have included a photo for identification purposes.
- □ I have included a letter identifying financial need and my parent has signed the letter as well.

2019-2020 ACHIEVER SCHOLARSHIP APPLICATION

PLEASE COMPLETE THIS FORM AND ATTACH TO YOUR APPLICATION!

Name _____

☐ Yes, I am interested in applying for a scholarship for the ACHiever program at ACH.

☐ I meet the following criteria:

- ☐ I will be entering the ninth grade in the fall 2019.
- ☐ Without a scholarship, I will not be able to participate in the program. I have included a letter explaining my financial need and my parent has signed the letter as well.
- ☐ My grade point average is certified by my counselor below.
- ☐ I have attached a letter of reference, from my counselor or a current teacher <u>on official school letterhead.</u>
- ☐ I have attached an essay of no more than 100 words indicating why participation in the program is important to me.
- ☐ If selected as a finalist, I am willing to participate in an interview with the selection committee.

COUNSELOR OR CURRENT TEACHER CERTIFICATION

☐ I certify that the above-named student will be entering the ninth grade in the fall and maintains a grade average of B or better.

☐ In my opinion, without a scholarship, this student will be unable to participate in the program.

_____
Signature of Counselor or Teacher

_____
Printed Name

_____ _____
Date School

_____
Phone Number

Arkansas Children's
HOSPITALS · RESEARCH · FOUNDATION

PHOTO / MEDIA RELEASE

AUTHORIZATION TO RELEASE HEALTH INFORMATION

ALL ELEMENTS ARE REQUIRED PRIOR TO INFORMATION BEING RELEASED

I authorize the use/disclosure of my protected health information as described below:

1. Who is authorized to use/disclose information: **Arkansas Children's Hospital and Arkansas Children's Inc.**

2. Who is authorized to receive the information: The public by way of publication including, but not limited to, ACH websites, ACH sponsored social media sites (Facebook, Twitter, YouTube.com, Pinterest, etc.), the internet, newspapers, television and/or radio broadcasts, books, brochures, magazines, motion picture film or video, photographic displays and scholastic/academic purposes. This may include use by other organizations ACH may affiliate with on specific projects; however, information released will only be used after ACH grants specific written authorization to use.

3. The specific information to be requested or released:

   a. Patient's name and medical case story.
   b. Any quotation or comment (made verbally, in writing, or video/audio recording) by the patient and/or concerning the patient.
   c. Photos or video/audio of the patient that may be taken and reproduced for use.

4. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by the Privacy regulations.

5. I understand that neither the patient nor his or her personal representative will be paid any publication (print/broadcast/web) and/or talent fees.

6. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or obtain a copy of any information used/disclosed under this authorization.

7. This authorization expires in twenty-five (25) years and remains effective from the date of submission/ authorization unless revoked by me in writing. I understand that I may revoke this authorization at any time by delivering a copy of my revocation to Arkansas Children's Hospital Marketing & Communications department except to the extent that action has been taken in reliance on this authorization.

Patient's Name (Please Print) Medical Record # Date of Birth

Signature of Patient or Representative Date

Print Name of Personal Representative Relationship to Patient

Send Original to Arkansas Children's Marketing & Comm, Slot 655 Revised on 06/20/17 Dan McFadden, APR

FOR HOSPITAL USE ONLY – LOCATION & PURPOSE