



VOCATIONAL SCHOLARSHIP APPLICATION
LEE HENDERSON MEMORIAL SCHOLARSHIP FUND
Job Skill Training, Certification Programs, and Trade Schools
INSTRUCTIONS AND DETAILS

Who can apply?

Current participants in the Ag Health Benefits group health benefit program can apply. Legal spouses of plan participants as well as children and grandchildren under age 25 can also apply. Children and grandchildren do not need to live with the plan participant.

If you are interested in pursuing a college degree, please complete the [Academic Scholarship Application](#).

Vocational scholarships are for:

- Those who wish to build job skills or learn a new trade;
- Aspiring students who are not yet in school;
- Current full- or part-time students at any vocational, educational, or job training program in California; and,
- Certificate programs including those at local community colleges in California.

Several scholarships will be awarded in amounts up to \$5,000 each.

Scholarships can be used for enrollment fees, books, supplies, and other program-related expenses. Past applicants and past winners may apply again. Applicants are eligible for up to two AHBA scholarship awards.

**Vocational scholarship applications are accepted twice each year,
from March 1-31 and from June 1-30.**

Vocational scholarship winners will be chosen by a Selection Committee based on:

- The applicant's motivation, character, ability, and potential;
- The applicant's financial need;
- Recent personal or professional letter(s) of recommendation.

Incomplete applications will not be considered.

Program Details

Available at www.aghealthbenefits.org/scholarships

Questions? Please call (707) 963-7191 or visit our office at 5 Financial Plaza, Suite 116, Napa CA 94558.

The vocational scholarship program is named in honor of Lee Henderson who led California Winegrower Foundation from 1973-2006 and dedicated her career to the agricultural community.



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Applicant's Name _____

Applicant's Address _____
Street City State Zip

Applicant's Email _____ **Telephone Number** _____

I. Please tell us about your affiliation with AG HEALTH BENEFITS ALLIANCE:

Are you the group health plan participant? YES NO

If YES, name of your employer: _____

Health Care identification number (HCID): **W00** - __ - ____ (located on your health care ID card)

If NO, name of the participant: _____

Please circle your relationship to the participant and provide the applicable date:

Spouse Date of Marriage _____

Child (under age 25) Date of Birth _____

Grandchild (under age 25) Date of Birth _____

Participant's employer: _____

Participant's Health Care identification number (HCID): **W00** - __ - ____ (this number is located on the participant's health care ID card)

II. Please tell us about yourself and your goals:

1. What is your current work and/or daily experience?

2. What do you intend to study? _____

3. Please provide information about the school or organization providing the training:

Name _____

Address _____

4. How will you use the knowledge you gain from this program?



III. Please tell us how this scholarship will help you financially:

1. What is your anticipated cost for enrollment?_____ Related Expenses?_____ TOTAL_____
2. What is your annual HOUSEHOLD income? Please include income from all sources. _____
3. Do you have any dependents? YES NO
 - a. If YES, how many? _____
4. Have you applied for or received any other funding to complete this program? YES NO
 - a. If YES, please provide the source and amount granted. _____
5. Are there other family, personal, financial, or special circumstances that you would like the Selection Committee to know?

IV. Please include at least one professional or personal letter of recommendation.

Application Deadlines: March 31 and June 30, 2023



Incomplete applications will not be considered. Please make sure you have included everything on the following checklist:

- Name, address, and contact information
- Name of your employer and health care ID (HCID) number (if you are the Ag Health Benefits participant)
- Details on your relationship to the Ag Health Benefits participant, their employer, and their health care ID (HCID) number (if you are not the Ag Health Benefits participant)
- Information about your educational goals
- Information about finances and costs
- At least one recent letter of recommendation

Return your completed application by March 31 or June 30, 2023

By email: info@aghealthbenefits.org

By mail: AHBAEF Scholarship Committee; 5 Financial Plaza, Suite 116; Napa, CA 94558

Scholarships will be awarded based on fair, objective, and non-discriminatory methods. Finalists will be chosen based on information provided in the written application and a virtual interview with the Selection Committee. AHBAEF will notify award recipients by mail. Scholarships will be issued upon proof of educational enrollment and acceptance of program terms.

By signing this application, I am stating that all information that I have submitted is truthful and accurate.

Signature of Applicant

Date

If under age 18, print the name of the Parent/Guardian Approving of Application Submission

Signature of Parent/Guardian

Date

AHBA Educational Foundation is a non-profit, 501c3 organization, tax ID #83-4433051. Thanks to Mike Wolf, the Michael L Wolf Trust, and many others for the generous donations that make this program possible.