

The Bertha Ross Hough  
Education Assistance Fund  
*“Bertha’s Fund”*



Administered by the



## Applicant Requirements

- Must be pursuing or preparing to pursue one of the following certifications/degrees: CNA, CMT, LPN, RN or BSN.
- Must be employed by St. Claire Regional Medical Center or Elliott County Nursing and Rehabilitation Center or affiliated with Sarah's Place in Sandy Hook, Kentucky.
- Must demonstrate academic achievement, service, and financial need.
- May request up to 80% of the total cost of your certification/degree program, with a maximum award of \$1,000.

Date \_\_\_\_\_

Name \_\_\_\_\_

Social Security # \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_

Home Address \_\_\_\_\_  
\_\_\_\_\_

Business Name (if currently employed) \_\_\_\_\_

Occupation \_\_\_\_\_ Business Phone ( ) \_\_\_\_\_

Business Address \_\_\_\_\_  
\_\_\_\_\_

Give information concerning current or last school(s) attended:

Name of school	City & State	Date entered	Date left	Diploma/degree
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**Please attach a grade transcript from your current or most recent school attended. If a transcript is not attached, please attach an explanation and list last year's grades.**

List any volunteer/service work or activities in which you have participated.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Would you be willing to appear before the Bertha's Fund Review Committee? Yes \_\_\_\_\_ No \_\_\_\_\_

**I certify that all information provided on this application is complete and correct and permit members of the Review Committee to contact any employer or reference listed on this application.**

Date \_\_\_\_\_ Signature \_\_\_\_\_

Please tell us a bit about your finances.

What School will you be enrolling in? \_\_\_\_\_

What degree or certification will you obtain? \_\_\_\_\_

Please detail the cost of the school you will be attending.			
	Cost	Funding	Source
Tuition	\$	\$	
Books	\$	\$	
Testing for certifications	\$	\$	
Other	\$	\$	
TOTAL	\$	\$	

What are your sources of income?	
Source	Monthly Amount
1	\$
2	\$
3	\$
4	\$

In this section please list your current monthly obligations	
Housing (rent or mortgage)	\$
Vehicle loans	\$
Credit Cards	\$
Student Loans	\$
Other Loans	\$
Medical	\$
Other Expenses	\$

Current Financial Position	
Cash in Checking	\$
Cash in Savings	\$
Other Cash	\$
Value of Vehicles	\$
Value of Real Estate	\$
Value of other Assests	\$
	Amount Owing: \$
	Amount Owing: \$
	Amount Owing: \$

Other Information / comments:

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### Your Application Packet must include:

- Completed Application Form
- A personal letter citing/detailing your reason(s) for wanting to work in healthcare
- Grade transcript from your current or most recent school
- Letter of reference from a current or former employer/supervisor
- Letter of reference from an individual of your choice

Application packets will be reviewed quarterly, with application deadlines of March 31, June 30, September 30 and December 31. Applications should be submitted to Tom Lewis, St. Claire Foundation Executive Director, in one of the following ways:

- Via mail at 222 Medical Circle, Morehead, KY 40351
- Via fax at (606) 783-6795
- Via email at telewis@st-claire.org
- Hand deliver to the St. Claire Foundation Office, 227 Allen Avenue, Morehead, KY

If you have questions, contact Tom Lewis at [Thomas.Lewis@st-claire.org](mailto:Thomas.Lewis@st-claire.org) or at (606) 783-6511.