



Note: This needs-based grant is available to spouses or children of injured Washington workers whose injury, while at work in Washington State, resulted in a permanent inability to return to work (a pension under the claim) or death. Money is potentially available for Running Start expenses, with approval. Documentation of expenses paid must be submitted and the applicant will receive reimbursement if approved. There is a maximum of \$599 per calendar year.

Running Start Grant Application

1. **NAME:** _____
FIRST MIDDLE LAST

2. **ADDRESS: Primary:** _____
STREET APT. NO.

CITY STATE ZIP

Alternate:

STREET APT. NO.

CITY STATE ZIP

EMAIL ADDRESS: _____

3. **TELEPHONE NO:** Primary: (_____) _____

Cell: (_____) _____

Name of nearest relative through whom you can always be contacted:

_____ Relationship _____

Address _____

Home Telephone _____ Business/Cell Telephone _____

Email Address _____

4. **DATE OF BIRTH:** _____

5. Name of injured or deceased parent or spouse (specify which):

_____ FIRST MIDDLE LAST

Labor & Industries Claim Number: _____

If claim is not under Washington's worker's compensation system, list the state or federal agency administering the claim and the claim number:

Date of Total Disability or Death: _____

6. Name and address of applicant's high school: _____

NAME OF HIGH SCHOOL

Date of graduation: _____

ADDRESS OF HIGH SCHOOL

7. Institution planning to attend:

Is this a four year college, community college, undergraduate program, or trade school.

8. Expected starting date: _____

9. Academic goals. Why did you choose running start and what are your plans upon graduation?

10. Have you been awarded any other financial aid? If so, please list what and the amount.

- 11. EDUCATIONAL BACKGROUND: List your high school and current GPA.**
- 12. Please state why you believe Kids' Chance should provide grant money for running start expenses.**
- 13. How did you learn about Kids' Chance?**

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

SIGNATURE OF APPLICANT

DATE

SIGNATURE OF PARENT OR GUARDIAN IF APPLICANT IS UNDER 18

DATE

ADDITIONAL DOCUMENTS REQUIRED

1. Official copies of high school transcript of grades and college/technical school transcripts (if attended)
2. Copy of signed Running Start Enrollment Verification Form
3. Financial aid printout from college or technical school, if applicable
4. Letter of recommendation (optional but recommended)
5. Authorization to verify entitlement to Labor & Industries benefits
6. Proof of enrollment (required prior to receiving any grant money)

More information may be requested if the injured or deceased worker's claim has been established in a jurisdiction other than Washington State Department of Labor and Industries.

Please return this completed application, a copy of your Running Start Enrollment Verification Form, and other required documentation to:

Mail:

**Kids' Chance of Washington
P.O. Box 185
Olympia, WA 98507-0185**

Email: info@kidschancewa.org

Questions? info@kidschancewa.org or call 360-943-3030

For more information, please visit - <https://kidschancewa.org>

REMINDER – APPLICATIONS ARE DUE JUNE 1 FOR FALL SEMESTER AND NOVEMBER 1 FOR WINTER AND SPRING.

AUTHORIZATION TO OBTAIN CLAIM INFORMATION

Kids' Chance of Washington Scholarship Applicant: Complete the first section only, date, and have the injured worker or surviving spouse sign. Please enclose this form with your completed scholarship application.

RE: INJURED WORKER/DECEASED WORKER NAME: _____

CLAIM NUMBER: _____

This will authorize the Department of Labor and Industries or the self-insured employer to provide worker's compensation benefit information or the nature of the medical condition to Kids' Chance of Washington. Please forward this information at your earliest convenience to Kids' Chance at P.O. Box 185, Olympia, WA 98504-0185 or fax to 360-943-2333.

DATED this _____ day of _____, 20_____.

Signature of Injured Worker or Surviving Spouse

Signature of Beneficiary, if over 18 years of age

For Dept. of Labor & Industries Use Only

Check the appropriate box below:

- Pension Benefits Section
- Claims Management -- *Is there a pending review by Pension?* Yes No
- Self-Insured Employer or Representative

Answer the following questions:

- ❖ Does the injured worker or surviving spouse receive a pension benefit? Yes No
If yes, how much per month?
- ❖ If over 18, does the beneficiary have a benefit or entitled to a benefit? Yes No
If yes, how much per month? _____

Date _____ Signed: _____
L&I Representative Name Title

L&I: Please fax completed form to 360-943-2333.