Health Careers Scholarship Program (HCSP) Personal Information Sheet

Health Plan of San Joaquin

Mountain Valley Health Plan

Personal Information		
Name:		
Date of birth:	Daytime phone:	Student ID#:
Personal email:	School email:	
Permanent mailing address:		Apt:
City:	State:	Zip code:
Address at school (if different from permanent mailing address):		
City:	State:	Zip code:
Anticipated year of college graduation:	Adult T-shirt size (XS, S, M, L, XL, XXL, XXXL):	

Alternate Information (if we're unable to contact you)	
Name of contact (parent/guardian if applicant is under 18):	Relationship to you:
Email address:	Phone:
Address:	
City:	State: Zip code:

Mentorship Information

If awarded the Scholarship, HPSJ/MVHP will provide you with a mentor to help you navigate the college system. Do you agree to participate in the Mentorship Program?* ☐ Yes ☐ No

**First-year college students only.*

*If yes, tell us your preference: ☐ Male mentor ☐ Female mentor ☐ No preference

I prefer a mentor in a specific field of healthcare: ☐ Yes ☐ No ☐ No preference

If yes, please specify: _____

*(Please note: Specifying your preference **does not guarantee** that you will be matched by your preference)*

Personal Information		
Print name:	Signature:	Date:
Parent/Guardian signature (if applicant is under age 18):		Date:

If there are any changes to your information as you progress through college, let us know at scholarships@hpsj.com. Thank you!