HCAI Department of Health Care Access and Information
2020 West El Camino Avenue, Suite 800
Sacramento, CA 95833
hcai.ca.gov

SCHOLARSHIP PROGRAM VERIFICATION (SPV) FORM

INSTRUCTIONS:

- This form is to be completed by students enrolled or scheduled to be enrolled in a health program that are pursuing a course of study leading to a health professional degree.
- This form must be signed by the Registrar's Office, Program Director, or Appropriate Designee **ONLY**.
- Applicant must upload the signed and completed form as part of their Department of Health Care Access and Information (HCAI) Scholarship Program application.
- Any missing or incomplete information will deem the applicant's application ineligible.

PLEASE ENTER ALL INFORMATION CLEARLY

First Name:	Last Name:	
Name of School/Institution:		
School/Institution Address:	Street:	
	City:	State:
	Zip/Postal Code:	County:
Major/Concentration:		
Degree Sought:	Program Start Date:	
By checking this box, Applicant certifies that they are enrolled or scheduled to be enrolled in a minimum of six (6) semester units/credits. ****A minimum of 6 semester units or its equivalent is required****	☐	

Type of Units: ◯ Semester ◯ Quarter ◯ Other:_____

****Enter your most recent GPA. If program has not started, you may enter your High School GPA if that is the highest education received to date.****

Student's Cumulative GPA:_____

Student's ***Expected*** Graduation/Completion Date:_____

TO BE SIGNED BY THE REGISTRAR'S OFFICE, PROGRAM DIRECTOR, OR APPROPRIATE DESIGNEE ONLY

I DECLARE UNDER PENATLY OF PERJURY THAT THESE STATEMENTS ARE TRUE AND CORRECT.

Signature	Date
Printed First and Last Name	Email