****Dyslexia Therapy Program  New Applicant

SCHOLARSHIP APPLICATION  Returning Student  
**2021-2022 School Year**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **STUDENT INFORMATION** | | | | | | | | | | | | |
| Student Full Name | | |  | | | | | | | | | |
| Student Full Address | | | | |  | | | | | | | |
| Student DOB |  | | | | | | MSIS ID |  | Entering Grade (2021-2022) | | |  |
| Parent Full Name | |  | | | | | | | | | | |
| Parent Full Address | | | |  | | | | | | | | |
| Parent E-Mail Address | | | | | |  | | | | Phone |  | |

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| --- | --- | --- | --- | --- | --- |
| **PREVIOUS SCHOOL INFORMATION**  *The information provided should reflect where the student has been in attendance for the 2020-2021 School Year.* | | | | | |
| District |  | | School |  | |
| Enrollment Date | |  | Withdrawal Date | |  |

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| **PROSPECTIVE SCHOOL INFORMATION**  *Information provided should reflect where the student will be in attendance for the 2021-2022 School Year.* | | | | | | | | | |
| **PUBLIC SCHOOL** | District Name | |  | | | | | | |
| Public School Name | | |  | | | | | |
| Public School Phone | | |  | | | Enrollment Date | |  |
|  | | |  | | |  | |  |
| **SPECIAL PURPOSE NON-PUBLIC SCHOOL** | | New Summit, North (Greenwood) | | | | 3D School, Petal | | | |
| New Summit (Jackson) | | | | Magnolia Speech School (Jackson) | | | |
| New Summit, South (Hattiesburg) | | | | Oxford University School (Oxford) | | | |
| School Phone | | |  | Enrollment Date | |  | |
|  | | |  |  | |  | |

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| **Required Documentation Must be Attached to this Application** | | | | | |
| The student has received an evaluation and has a diagnosis of dyslexia determined by  a licensed psychometrist, psychologist, or speech language pathologist as specified in Miss. Code § 37-173-15. | | | | Yes  No | |
| Documentation of Acceptance and Enrollment into new school is provided. | | | | Yes  No | |
| *I do hereby certify that all information provided by me in this application and the attached documents are true and correct to the best of my knowledge. I further understand that in the event I have knowingly and willfully made any false statements, my student will be immediately removed from the Dyslexia Therapy Scholarship program and all funds will be forfeited.* | | | | | |
|  |  | |  | | |
| Parent/Legal Guardian Signature | | Date | | |  |

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| --- | --- | --- |
| **MDE Office Use Only** | | |
| Date Received | Approved ⬜ Denied ⬜ | Date Notification Sent |
| Reason for Denial: | | |

**Please send the completed application and attachments (Certified Mail Return Receipt Requested) to:**

Mississippi Department of Education  
Office of Elementary Education and Reading  
Attn: Dyslexia Scholarship  
P.O. Box 771, Jackson, MS 39205