



Dear Parent/Teacher:

Thank you so much for your interest in the ACHiever program!

The ACHiever program was initially designed for young women entering the ninth grade and has been ongoing in the community for the past 20 years. With its success, in 2018 the program grew to offer an ACHiever program for young men. This program is sponsored by the Arkansas Children's Hospital's Auxiliary, a group of volunteers who work to raise funds and awareness for ACH. Today, any ninth grade student can apply to the program!

We believe that this program is beneficial in exposing young women and men to Arkansas Children's Hospital, introducing them to a variety of wonderful medical careers, and encouraging the importance of philanthropy. In addition to the community service hours earned through program attendance, ACHiever participants may earn additional service hours working in non-patient care areas.

The program will meet once a month from September to April for educational sessions and there will be a handful of community service opportunities through the seven month program. Our first educational session is an orientation, with a parent, in September. Educational sessions will take place one Monday of each month from 5:30 – 6:30 pm. Educational sessions may include presentations or tours of Angel One Transport Department, the David M. Clark Center for Safe and Healthy Children, Injury Prevention, Arkansas Children's Foundation and more! The program will culminate in April with a graduation dinner for ACHievers and their parents.

Please share this information with your son or daughter. If he or she decides to make a commitment to the ACHiever program, we ask that you mail the ACHiever Program Application with a tax deductible deposit\*.

Also, thanks to the generosity of local businesses and individuals, we have scholarships available! If you would like to apply for a scholarship, please check scholarship application on the payment box.

Once your son/daughter has been accepted into the program, you will be notified and additional detailed information will be mailed to you. Should you have any questions, please don't hesitate to call us.

We look forward to having your son/daughter as an ACHiever!

A handwritten signature in blue ink that reads "Jessica L. Rivera-Hudson". The signature is fluid and cursive.

Jessica L. Rivera-Hudson  
501-364-1440

*\*The deposit fee is \$500.*

# 2022-2023 ACHiever Program Application

**\*\*Please enclose a photo that will be used for identification purposes only**

**PROGRAM APPLYING TO: BOY/GIRL (please circle)**

**APPLICANT NAME:** \_\_\_\_\_ **AGE** \_\_\_\_\_

SCHOOL ATTENDING FALL 2022: \_\_\_\_\_ **T-SHIRT SIZE** \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

APPLICANT PHONE: \_\_\_\_\_ APPLICANT'S E-MAIL: \_\_\_\_\_

**PARENT/S:** \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

\_\_\_\_\_ CELL PHONE: \_\_\_\_\_

ADDRESS (if different from above): \_\_\_\_\_

PARENT/S EMAIL ADDRESS \_\_\_\_\_

**SPONSOR NAME (IF OTHER THAN PARENTS):** \_\_\_\_\_

RELATIONSHIP TO APPLICANT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

BUSINESS (if business sponsoring): \_\_\_\_\_

BUSINESS ADDRESS: \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

APPLICANT'S CURRENT ACTIVITIES/INTERESTS:

WHY ARE YOU INTERESTED IN THE ACH ACHIEVER PROGRAM? \_\_\_\_\_

## **APPLICATION MUST BE MAILED TO:**

*ACHiever Program, Arkansas Children's Hospital,  
1 Children's Way, Slot 661, Little Rock, AR 72202*

### **PAYMENT OPTIONS (CHECK ONE):**

- My check for the total amount of \$1,200 is enclosed.
  - My check for the deposit of \$500 is enclosed. Invoice me remainder per payment schedule.
  - Scholarship Application
  - Please charge \$1,200 to my credit card.
  - Please charge \$1,200 to my credit card. Please invoice me remainder per payment schedule.
- Check one:     VISA     MasterCard     American Express     Discover

Name as it appears on credit card: \_\_\_\_\_

Credit Card #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

***Please make checks payable to: Arkansas Children's Hospital Auxiliary***

## **2022-2023 ACHiever SCHOLARSHIP INFORMATION and APPLICATION**

A child may be sponsored by a parent, relative, friend, business or civic organization. All participant fees will be used to support Arkansas Children's Hospital Auxiliary fundraising efforts.

A limited number of scholarships are available for students who meet the following criteria:

1. Will be entering the ninth grade in the fall.
2. Will be unable to participate financially without a scholarship.
3. Student must submit essay of no more than 100 words indicating why participation in the program is important to the student, signed by parent or school counselor.

If your child is interested in participating and he or she meets the above criteria, please complete the enclosed application, mark scholarship application on the payment box and attach it, along with your child's essay, before mailing. No deposit is necessary.

## **2022-2023 ACHiever PLEDGE SCHEDULE**

The participation fee for the ACH ACHiever program is \$1,200. Please note that this fee is **non-refundable** once the applicant has been accepted into the program. For your convenience, the following payment schedule is offered:

Due with Application..... \$500  
Invoiced monthly beginning Sept 2022 through March 2023 ...\$100

Balance is due prior to April 2023

The above payment schedule may be followed or total payment may be made at any time. **This is a tax-deductible contribution to Arkansas Children's Hospital. Since you will receive no direct benefit as a result of your gift, you may claim the full amount as a charitable deduction, according to the IRS guidelines.** We accept personal or business checks, cash, VISA, MasterCard, American Express and Discover.

**PLEASE COMPLETE THIS FORM AND ATTACH TO YOUR APPLICATION**



HOSPITALS • RESEARCH • FOUNDATION

## PHOTO / MEDIA RELEASE AUTHORIZATION TO RELEASE HEALTH INFORMATION

ALL ELEMENTS ARE REQUIRED PRIOR TO INFORMATION BEING RELEASED

**I authorize the use/disclosure of my protected health information as described below:**

1. Who is authorized to use/disclose information: **Arkansas Children's**
2. Who is authorized to receive the information: The public by way of publication including, but not limited to, Arkansas Children's websites, Arkansas Children's sponsored social media sites (Facebook, Twitter, YouTube.com, Pinterest, etc.), the internet, newspapers, television and/or radio broadcasts, books, brochures, magazines, motion picture film or video, photographic displays and scholastic/academic purposes. This may include use by other organizations Arkansas Children's may affiliate with on specific projects; however, information released will only be used after Arkansas Children's grants specific written authorization to use.
3. The specific information to be requested or released:
  - a. Patient's name and medical case story.
  - b. Any quotation or comment (made verbally, in writing, or video/audio recording) by the patient and/or concerning the patient.
  - c. Photos or video/audio of the patient that may be taken and reproduced for use.
4. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by the Privacy regulations.
5. I understand that neither the patient nor his or her personal representative will be paid any publication (print/broadcast/web) and/or talent fees.
6. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or obtain a copy of any information used/disclosed under this authorization.
7. This authorization expires in twenty-five (25) years and remains effective from the date of submission/ authorization unless revoked by me in writing. I understand that I may revoke this authorization at any time by delivering a copy of my revocation to Arkansas Children's Marketing & Communications department except to the extent that action has been taken in reliance on this authorization.

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**Patient's Name (Please Print)**

**Medical Record #**

**Date of Birth**

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**Signature of Patient or Representative**

**Date**

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**Print Name of Personal Representative**

**Relationship to Patient**

Send Original to AC Marketing & Communications Department, Slot 655    Revised on 07/05/17

**FOR HOSPITAL USE ONLY – LOCATION & PURPOSE** \_\_\_\_\_