The Reginald Anderson Memorial Scholarship

"Reginald Anderson was full of life, love, and laughter. His beautiful and contagious smile would light up a room. Reginald passed away in 2014 after a courageous battle with glioblastoma, but his legacy lives on in the Reginald Anderson Memorial Scholarship.

Education was very important to Reggie. He graduated from South Windsor High School where he played football as a defensive lineman. He advanced to Springfield College and graduated with a B.S. in Social Services. He was employed by the State of Connecticut as an adult probation officer, enjoyed his job, and took pride in his role. He treasured traveling and learning new things. Reggie also loved shopping and had quite the hat collection. His kind, gentle soul lives on in the memories he has left his loved ones with." ~ *Gina Lowther*

The Connecticut Brain Tumor Alliance, Inc. is pleased to offer the Reginald Anderson Memorial Scholarship, founded in 2015 by Gina Lowther with generous contributions from family, friends, and community members, to honor the life and legacy of Reginald Anderson.

We are now accepting applications for the 2026 Reginald Anderson Memorial Scholarship program. Applications must be postmarked by May 15, 2026 and scholarship recipient(s) will be notified by May 29, 2026.

Connecticut Brain Tumor Alliance Caregiver Scholarship Program

The Connecticut Brain Tumor Alliance, Inc. was established to provide hope and support to brain tumor patients and caregivers whose lives have been impacted by a brain tumor diagnosis. The Reginald Anderson Memorial Scholarship will be awarded based on the criteria listed below.

Eligibility: Applicants must meet all of the requirements listed below.

1. Must be an immediate family member of someone diagnosed with a brain tumor.
2. Must be currently enrolled in an accredited higher education institution or entering college in the semester following the award.
3. Must be a Connecticut resident and U.S. citizen.
4. Must have demonstrated financial need.

Checklist: All applications must include the following:

- Complete application forms
- Copy of college transcript or course registration/acceptance letter if you are an incoming freshman
- Resume including list of volunteerism or advocacy on behalf of brain tumor patients and their caregivers
- A typed statement about how your brain tumor journey has shaped, changed, and/or reinforced the principals by which you live your life. Please also comment on how you have used or plan to use your brain tumor experience as a caregiver to positively impact the lives of others.
- Signed Authorization statements
- A brief typed explanation of your current financial situation, how your family's brain tumor experience has increased your financial need, and how you will use the money if awarded.

Submission: Please mail completed application to:

The Reginald Anderson Memorial Scholarship
c/o The Connecticut Brain Tumor Alliance, Inc.
P.O. Box 370514
West Hartford, Connecticut 06137

Note: Please do not send applications via certified mail. You may email your application (as an alternative to mailing it) as a PDF file to scholarship@ctbta.org. Please include all sections in one file.

Application Deadline: All applications must be postmarked/timestamped by May 15, 2026.
Award Notification Date: Scholarship recipient(s) will be notified by May 29, 2026.

2026 REGINALD ANDERSON CAREGIVER SCHOLARSHIP		
SECTION A: PERSONAL INFORMATION		
First Name:	Middle Initial:	Last Name:
Address:		
City:	State:	Zip Code:
Home Phone:	Cell Phone:	
Email Address:		
Relationship of applicant to family member diagnosed with brain tumor:		
Gender: _____Male _____Female	Date of Birth (mm/dd/yy):	Age:
SECTION B: CURRENT EDUCATION INFORMATION		
Current Grade Level as of Fall 2026:		
School Name:		
School Address:		
City:	State:	Zip Code:
Registrar's Office Phone Number (for verification only):		
Current GPA or High School GPA (for college Freshmen Only):		
Major:	Minor:	
** Please attach a copy of your official transcript		
SECTION C: MEDICAL HISTORY		
Diagnosis:		
Date of Diagnosis:	Age at Diagnosis	
Is your family member currently undergoing treatment? _____Yes _____No		
Name and city of treatment center:		
Medical provider contact information and phone number (for verification only):		
** Please attach Physician Verification form. If a physician's verification is not available, please provide a reference from another professional, such as a school guidance counselor, who will verify your relationship to a family member who has been diagnosed with a brain tumor.		
SECTION D: FINANCIAL NEED		
Please list all total cost of education expenses and sources of financial assistance you will be receiving for the upcoming school year, including other scholarships.		
Total Estimate 2026-2027 Education Costs:		
Financial Aid Package from Schools, Loans & Other Sources:		

2026 REGINALD ANDERSON CAREGIVER SCHOLARSHIP	
SECTION E: AUTHORIZATIONS	
PLEASE READ EACH STATEMENT AND SIGN BELOW	
1) I CERTIFY THAT ALL STATEMENTS IN THIS APPLICATION ARE TRUE. I UNDERSTAND THAT THIS APPLICATION WILL BECOME THE PROPERTY OF THE CONNECTICUT BRAIN TUMOR ALLIANCE. I AGREE THAT MY ESSAY MAY BE REPRINTED IN PART OR IN FULL FOR THE PURPOSES OF EDUCATING, SUPPORTING, AND HELPING OTHERS AFFECTED BY A BRAIN TUMOR. 2) I AUTHORIZE THE REGISTRAR OF MY SCHOOL/COLLEGE/UNIVERSITY TO PROVIDE A REPRESENTATIVE OF THE CONNECTICUT BRAIN TUMOR ALLIANCE WITH INFORMATION REGARDING MY ENROLLMENT STATUS AND VERIFICATION OF MY GPA AND/OR CREDITS EARNED. 3) I HEREBY AUTHORIZE _____ (MEDICAL PROVIDER OR OTHER NAMED PROFESSIONAL LISTED ON THE APPLICATION) TO PROVIDE INFORMATION ABOUT MY FAMILY MEMBER'S MEDICAL CONDITION AND BRAIN TUMOR DIAGNOSIS TO A REPRESENTATIVE OF THE CONNECTICUT BRAIN TUMOR ALLIANCE IN ORDER TO SUPPORT MY SCHOLARSHIP APPLICATION.	
Signature:	Date:
Printed Name:	

PHYSICIAN OR OTHER PROFESSIONAL VERIFICATION FORM	
Please have your family member's physician complete this form and submit it with your application. If a physician's verification is not available, please provide a reference from another professional, such as a school guidance counselor, who will verify your relationship to a family member who has been diagnosed with a brain tumor.	
Dear Doctor or other qualified professional: The following applicant has applied for a Reginald Anderson Caregiver Scholarship. Your cooperation in verifying his/her family member's brain tumor diagnosis is greatly appreciated. Please complete this form and return it to the applicant. The applicant is responsible for including this form in his/her application. Thank you for your assistance in this matter. If you have any questions, please feel free to contact the Connecticut Brain Tumor Alliance at scholarship@ctbta.org. Christopher Cusano CEO, Connecticut Brain Tumor Alliance, Inc.	
Applicant's Full Name:	
Family Member's Diagnosis:	
Date of Diagnosis:	Age at Diagnosis:
Hospital/Neurology Practice or Relevant Professional Practice/School	
Physician's/Professional's Name:	
Address:	
Phone	
Physician's/Professional's Signature:	Date: