

YMCA of Saratoga

Financial Assistance Application

Date Submitted: _____

Facility applying for: Full Facility Membership ___ **Malta** ___ **Corinth** ___

Please fill out the following information and attach the necessary documents (photocopies only) and return to the YMCA of Saratoga. Completed applications and documents can be mailed to: YMCA of Saratoga, Attn: Financial Assistance Director, PO Box 4610, Saratoga Springs, NY 12866. **Please print clearly and complete front and back pages.**

HEAD OF HOUSEHOLD INFORMATION

| | | | |
|----------------|----------------------------|----------------|------------------------|
| Last Name | First Name | Middle Initial | Social Security Number |
| Street Address | | | Employer |
| City | State | Zip | Work Phone |
| Home Phone | Age of Person Listed Above | Occupation | How Long |

TOTAL NUMBER OF PERSONS RESIDING IN HOUSEHOLD

- A. Total Number of Children _____
- B. Total Number of Adults _____
- C. Total Persons in Household (A + B)

MARTIAL STATUS OF PRIMARY ADULT

- Single
 Married (living w/spouse)
 Married (spouse absent)
 Divorced
 Legally Separated
 Widowed

SPOUSE OR CONTRIBUTING ADULT Name _____ Age _____

Living in the same household Yes No Social Security _____

Occupation _____ Name of Employer _____

| Child(s) Name(s) | Age | School | Birth Date |
|------------------|-------|--------|------------|
| 1. _____ | _____ | _____ | _____ |
| 2. _____ | _____ | _____ | _____ |
| 3. _____ | _____ | _____ | _____ |
| 4. _____ | _____ | _____ | _____ |
| 5. _____ | _____ | _____ | _____ |

OTHER INDIVIDUALS LIVING IN THE SAME HOUSEHOLD (roommates, relatives, etc.)

Name _____ Age _____ Relationship _____

ARE YOU A CURRENT MEMBER OF THE YMCA of Saratoga _____

APPLICATION FOR FINANCIAL ASSISTANCE IS FOR:

- Membership
 Program (List _____)
 Child Care*
 Other (Please List) _____

* If application is for child care or camp program, you must first contact Department of Social Services Child Care Assistance to determine eligibility. Please contact Saratoga County DSS Child Care at 884-4283 or 4280.

WHAT IS THE DOLLAR AMOUNT THAT YOU ARE ABLE TO PAY?

MEMBERSHIP \$ _____ Per Month
PROGRAM \$ _____ Per session/class (Please list class) _____
CHILD CARE \$ _____ Per week

MONTHLY ITEMIZED INCOME

Wages, salaries & tips \$ _____
Unemployment compensation \$ _____
Social Security Benefits \$ _____
Child Support \$ _____
State subsidized funding \$ _____
Alimony \$ _____
Other: _____ \$ _____

TOTAL MONTHLY INCOME \$ _____

Proof of income must be furnished. If you are a full-time student, please attach proof of enrollment.
The Financial Assistance application cannot be processed without proof of income.

WHAT SHOULD WE KNOW ABOUT YOUR CIRCUMSTANCES AS WE CONSIDER YOUR REQUEST? _____

HOW DID YOU HEAR ABOUT THE YMCA FINANCIAL ASSISTANCE PROGRAM? _____

I hereby declare that the information provided is accurate and agree to supply additional information if requested. I understand that falsification of information submitted will result in discontinuation of services provided and could require repayment of full fees. I authorize the YMCA to verify the above information. I understand that Financial Assistance awards may be assessed several times a year. All information provided herein will be kept confidential.

Signature of Applicant

Date

| For YMCA Office Use Only | | | | |
|----------------------------------|----------------------------------|---|----------------------|------------------------|
| _____ | \$ _____ | \$ _____ | _____ % | \$ _____ |
| Type of Membership or Program | Cost of Membership or Program | Amount Awarded | Percentage of Fee | Recipient's Portion |
| _____ | _____ | Notified by Mail or Phone (circle one) | | |
| YMCA Staff Signature | Date of Award | | | |
| Notes: _____ | | | | |