CONFIDENTIAL
Application for Financial Assistance

Date received in office: _____

Membership/Program Information:

Please indicate the membership/program for which you are applying:

Membership Type		Program(s)	
____Yearly Individual ____Yearly Family	____Bank Draft Individual ____Bank Draft Family	____Healthy U ____Swim Lessons	____Other (please specify)_____

Applicant Information:

First Name: _____ Last Name: _____

Gender: _____ Date of Birth: _____ Address: _____

City/State/Zip: _____Email Address: _____

Home Phone: _____ Work Phone: _____

Marital Status: ____Single ____Married

Employer: _____ Employer Address: _____

City/State/Zip: _____

Occupation: _____ Length of Employment: _____

Spouse Information:

First Name: _____ Last Name: _____

Gender: _____ Date of Birth: _____ Address: _____

City/State/Zip: _____Email Address: _____

Home Phone: _____ Work Phone: _____

Employer: _____ Employer Address: _____

City/State/Zip: _____

Occupation: _____ Length of Employment: _____

Dependent Information:

Only children who are born to you, legally adopted/guardian by you, and claimable on your taxes will be considered dependents. Children over the age of 18 are considered a dependent only if you can claim them on your federal income tax form.

First Name	Last Name	Date of Birth	Age	Relationship to Applicant

Monthly Household Income – All Sources

(This section must be completed or your application will be considered incomplete)

Monthly Income		Monthly Expenses	
(Gross) Wages/Salaries/Tips	$	Rent/Mortgage	$
Unemployment	$	Utilities/Phone	$
Social Security Compensation	$	Food	$
Child Support	$	Clothing	$
Aid to Dependent Children	$	Car/Insurance	$
Food Stamps	$	Alimony	$
Alimony	$	Child Support	$
Housing Assistance/Section 8	$	Medical	$
Retirement/Pension	$	Other	$
DHS Subsidy	$		
Other	$		
Total	$	**Total**	$

Your application will not be processed without copies of the following: A) Most recent year's Federal Income Tax form (first two pages); B) Four recent paycheck stubs; C) Proof of child support and/or social security benefits.

Is any portion of your membership or program fees reimbursable by your insurance company?

Yes _____ No _____

If yes, under what health insurance plan are you currently covered? _____

How much can you afford to pay? _____

Is the applicant currently a member of The REC Center? _____

Explain why you would like to be considered for financial aid at The REC Center (include any special circumstances)

_____

_____

_____

_____

*I realize that The REC Center's financial resources are limited and; therefore, if eligible, I am expected to seek additional funding from other sources, if applicable. I also certify that the above information is true and complete to the best of my knowledge.

Signature of Applicant or Parent/Guardian **Date**

The financial assistance committee meets on the third Wednesday of every month. Applications should be turned in by that day to be considered for that month. Applicants should receive a letter notifying them of approval/denial during the following week.

For Office Use Only

Membership/Program _____ Regular Fee _____

Financial Assistance % _____ Start Date _____

REC Center % _____ FA offer Exp. Date _____

Monthly Dues $ _____ Program Fees $ _____

Yearly Dues $ _____