Edgar may Health and Recreation CENTER

ACCESS FOR ALL

Please complete this form and provide proof of income. Return to Edgar May Health & Recreation Center, 140 Clinton Street, Springfield, VT 05156.

1 BASIC INFORMATION

Name ____________________

Mailing Address ____________________

City ____________________

State __________ Zip Code __________

Phone # ____________________

Email ____________________

Date of Birth ____________________

2 PLEASE PROVIDE THE FOLLOWING

I am:

- ◯ First time applying or not currently receiving assistance
- ◯ Currently receiving assistance (Renewing)

I can afford $________ per month.

Enclosed is a copy of:

- ◯ Most recent tax return
- ◯ Social security compensation
- ◯ Most recent pay stub
- ◯ Other *(specify)*

Documentation from the list above is required to verify income and must be provided with this application. The EdgarMay can make photo copies of original documents if requested. All financial information is kept in a secure location.

3 I AM APPLYING FOR

membership

- ☐ **ADULT** (25-61)
- ☐ **YOUNG ADULT** (19-24)
- ☐ **SENIOR** (62+)
- ☐ **TEEN** (14-18)
- ☐ **YOUTH** (3-13)
- ☐ **1-ADULT FAMILY**
- ☐ **2-ADULT FAMILY**
- ☐ **2-SENIOR COUPLE**

program

- ☐ **CLASS ADD-ON**
- ☐ **SWIMMING LESSONS**
- ☐ **ADVENTURE CAMP**
- ☐ **SWIM TEAM**
- ☐ **PRESCRIPTION FOR WELLNESS**
- ☐ **OTHER**

4 HOUSEHOLD INFORMATION

First Name	Last Name	Relationship	Age	Dependent on 1040?

5 INCOME (PER MONTH)

$ ________	Adult 1 Gross Income	$ ________	Food Stamps
$ ________	Adult 2 Gross Income	$ ________	Welfare/TANF/Reach Up
$ ________	Child Support	$ ________	Retirement Funds
$ ________	Social Security	$ ________	Other (specify)
$ ________	Unemployment	$ ________	Other (specify)

Total Income: $ ________

For Office Use Only

Please leave this section blank.

Date Received: ____________________

Proof of Income: ____________________

Received By: ____________________

Date Reviewed: ____________________

Scholarship %: ____________________

Date to reapply: ____________________

6

I am requesting assistance from the Edgar May Health and Recreation Center due to my personal circumstances. I verify that all information submitted is complete and accurate. If my situation changes, I agree to notify the EdgarMay within the designated time. If I submit false or inaccurate information or fail to notify the EdgarMay of a change within 30 days, I may be terminated from the scholarship program. I understand that as a participant in this program, I may be asked to provide proof of income at any time. If I fail to provide verification, my monthly rate will be adjusted. I understand that I need to reapply annually for the scholarship program.

____

Signature Date