

**Pike County YMCA
Personal Pricing/Financial Assistance Application**



Name _____ Birth Date _____ Gender _____

Address _____ City _____ State _____ Zip Code _____

County _____ Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____

Membership Type (Please Mark box for the type you wish to qualify)

Family Adult Husband and Wife Adult Senior Husband and Wife Senior

Family/Household Information:
(Family consists of up to 2 married Adults living in the same household and all IRS allowable dependent children.)

NAME	Birth Date	M/F	School (if applicable)

All submitted income verification must have the dollar amount that you are receiving on a monthly basis. If you do not have this information please contact your employer or caseworker before submitting your application. Completed and properly documented applications will be reviewed within 10 working days.

Monthly Gross	Applicant Inc	2 nd Adult
Wages/Salary		
Child Support		
Alimony		
Govt. Assistance		
Food Stamps		
Housing Assistance		
Other Income		

Required Documentation

Please submit your completed application along with all current proof of income that applies to you including:

- 2 current paycheck stubs from each adult in household
- Federal Income Tax Return (w 2's are not accepted)
Attach copies of your most current filing year (1040, 1040A, etc. If you are self-employed or own a business include Schedule C
- Unemployment
- Disability
- SSI/Social Security
- Government Assistance:
Food Stamps (EBT Cards are not accepted)
Housing Assistance
Foster Care
- Child Support/ADC/Alimony
- Student Loans (only of used for living expenses)
- Trust Funds/IRA's/Retirement Income
- Parental Support:
If you are being claimed as a dependent by your Parents/Guardians on their Federal Income Tax return your application will be reviewed based on the combination of both you and your Parents/Guardians total gross annual income. Please submit a copy of your Parents/Guardians Federal Income Tax return.
- Ward of the State - will be reviewed based on Guardians total gross annual income and compensation for Wards care.

I certify that all provided information is accurate and complete to the best of my knowledge.

Signed _____

Date _____

For Office Use Only:

Date _____ Membership Type _____ Subsidy Code _____

Mo. Member Fee _____ Process Fee Amt. _____ Total Draft Amt. _____

Annual Rate _____ Subsidy Percentage _____

Reviewed by: _____