

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 _____