FOR A BETTER US

FINANCIAL ASSISTANCE APPLICATION FORM *must be fully completed

I am applying for: Membership (type) _____ or Program_____

Name: _____ Sex: M F ☐ Married ☐ Single

Address: _____ City: _____ Zip: _____

Cell # _____ Home # _____ Email _____

Household Size: _____ Adults _____ Children Household Annual Gross Income $_____

In determining eligibility for financial assistance, all sources of household income are taken into consideration. Proof of income (last year's Federal Income Tax return and/or most recent pay stubs) for all persons in the household must accompany this application

Applicants Income:

Employer: _____ Hourly Wage: $_____ # Hours per Week: _____

Spouse Income:

Employer: _____ Hourly Wage: $_____ # Hours per Week: _____

Income from other sources: This should include any social service assistance, child support, food stamps, stipends, unemployment income, disability income, and earnings from investments, wages, tips and cash and barter income.

$ _____ Source _____ Frequency _____

$ _____ Source _____ Frequency _____

What membership rate do you believe you could afford? $_____ / month

- The individual monthly portion of the financial assistance membership may be paid by cash, credit card or EBT and may be set up on a monthly draft. Individuals that qualify for reduced memberships will be approved for a 12-month period. Individuals must then reapply if they wish to continue. This membership is for general usage only and does not include Membership Plus.
- This YMCA membership is for family or one or more people living in the same household (requires verification).
- I understand that the information requested on this form is considered privileged and will be held in confidence. I authorize the Brainerd Family YMCA to make whatever inquiries deemed necessary to verify the information provided above.
- Membership may be activated immediately at your self-selected level: however, this information must be verified within one week from join date. If not, the membership rate will convert to the full rate.

Member Signature _____ Date ____ /____ /____

YMCA OFFICE USE ONLY

Membership Type: _____ Rate: $_____ per month % of Assistance _____

Program Fees Reduced _____% FA approved on: _____ Expires: _____ YMCA Staff_____

Follow Up_____

Brainerd Family YMCA • 602 Oak Street • Brainerd MN 56401 • 218-829-4767 • Fax 218-829-4768

Please share any circumstances which we should consider in determining the amount of assistance you may qualify for, e.g. medical expenses, financial support of extended family members, loss of job or other income, or any other pertinent information you feel comfortable sharing.

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