



YMCA of Greater Michiana Financial Assistance for Membership

Branch: **BHSJ** **DTSB** **NB** **OB**

Please note: This application requires the income of everyone in the household, including those not on the membership. We cannot accept \$0 income. Incomplete paperwork or income requirements may delay your assistance process. If you are eligible for SNAP (Supplemental Nutrition Assistance Program) or cash assistance through the state, present your Explanation of Benefits, and receive instant approval of 45% off your monthly membership rate. Include pages 1 & 2 with application. Instant approval does not apply to programs. **PLEASE PRINT ELIGIBLY**

Address: _____

Phone: _____ Email: _____

Family members residing at the address above (proof may be required). List additional members in the notes on back

Family Member's Name	Date of Birth	Age	Name of Employer and/or School

INCOME (salary, self-employed, unemployment) please attach proof - required

Family Member's Name	Income Type	Monthly Income	Annual Income
		\$	\$
		\$	\$

UNEARNED INCOME (SS, Disability, Retirement, Pension, Child Support) please attach proof - required

Family Member's Name	Unearned Income Type	Monthly Income	Annual Income
		\$	\$
		\$	\$
		\$	\$
		\$	\$

STATE AIDE (food and/or cash assistance) please attach proof - required

Monthly Benefits \$_____ Annual Benefits \$_____

Please list all family members approved for state benefits. List additional family members in the notes below

Name	Name	Name
1	2	3
4	5	6

Current Federal Tax Return – pages 1 and 2 and/Schedule C must be included. (initials) _____

I certify that the information I have provided is true and complete to the best of my knowledge. I agree to notify the YMCA if my financial status should change. I understand that inaccurate and incomplete information may cause termination from the financial assistance program. I understand that if my application is approved, my assistance will be reviewed on an annual or semi-annual basis and adjusted based on my circumstances at that time.

Signature _____ Date _____

Additional notes to help determine your eligibility:

Additional information needed for PROGRAM ASSISTANCE

Branch: BHSJ DTSB NB OB Camp EB Northside

Program: ___ Infant/Toddler ___Preschool ___Y-Club ___Day Camp ___Overnight Camp

If applying for childcare/camp you must first apply for state assistance. (not needed for Camp Eberhart)

MI: Michigan.gov/MIBridges (must be denied) IN: Mybrightpoint.org (must be denied or not covered in full)

Please provide a copy of your letter showing if you are partially approved or denied.

List of children needing care (add additional children on the back)

Name	Age	Program

Questionnaire:

Please tell us the reason that you require assistance for childcare if you were denied by the state.

If you are a single parent who is the secondary parent(s)?

Please list their role in providing childcare.

Are they providing Child Support? If yes, court document w/benefits required. If no, why?

OFFICE USE ONLY

Weekly Income \$ _____

Weekly Child Care Cost \$ _____

% of Income _____

% of Income after FA \$ _____

Recommendation: 10% 20% 30% Other _____%

NOTES: (please print)

Director: _____ COO: _____ Date: _____