



YMCA OF THE INLAND NORTHWEST 2019 PROGRAMS & CHILDCARE FINANCIAL ASSISTANCE APPLICATION

FINANCIAL ASSISTANCE FOR: Aquatics, Camp Reed, Day Camps, Early Childhood Education & Care, Health & Wellness, School-Age Care Programs, Teen Programs, Youth Classes and Youth Sports. Birthday parties are not eligible for assistance.

DO NOT USE THIS FORM for assistance with Membership fees. For the YMCA's Membership for All Program please see a Member Service Representative at any Y facility.

APPLICATION INSTRUCTIONS

1. Complete Sections I through III of the application. Section IV is optional. Provide email address and phone number. Sign and date page 2.
2. Provide proof of household income for all adults listed on the application.
3. Attach copy of 2018 Tax Return/Form1040, pages 1&2 only. DO NOT send W-2 forms.
4. If your current household income has changed significantly from your 2018 tax return, provide proof of household income such as YTD pay stubs w/explanation.
5. Attach documentation for all amounts listed below in Section III "Annual Household Income". Provide proof of dependency. All supporting documentation must be provided with the application or it will be returned and not processed.
6. Return this application and copies of all required documents to the address, email, or fax noted on the bottom of page 2.
7. Assistance expires annually and is valid through 4/30/2020.
8. **Applications that are incomplete or do not have correct/sufficient documentation will be returned, unprocessed.**

Business Office Use Only

Cen Vly Nth Sth Sandpt
 Approved at _____ % Denied
 Email Letter Phone In Person
 Date _____ Initial _____
 # Adults _____ #Children _____
 Application returned, additional information required. Request for additional information sent on: _____

I. ADULTS IN THE HOUSEHOLD (if more than two adults please attach another paper)

1st Adult _____ Gender _____ Birth Date _____ *Race/Ethnicity _____
First M/I Last
 Address _____ City _____ State _____ Zip _____ Phone: _____
 Email: _____

2nd Adult _____ Gender _____ Birth Date _____ *Race/Ethnicity _____
First M/II Last
 Email: _____ Relationship to 1st Adult _____

II. ALL DEPENDENT CHILDREN IN THE HOUSEHOLD **Note:** Proof of dependency required for all children listed

First	Middle Initial	Last	Gender	Birth Date	Relationship to Adult	*Race/Ethnicity

Financial Assistance is awarded on the basis of need without regard to race, color, handicap, sex, age, or national origin.

* For statistical reporting purposes. (A) African American (B) Asian (C) Caucasian (D) Hispanic (E) Native American (F) Multiracial

III. ANNUAL HOUSEHOLD INCOME -----Please supply **ANNUAL** amounts for all listed below:

Gross Salary - All Household Members	\$ _____	-> If \$0, and single parent, please explain: _____
Alimony – Court Documentation	\$ _____	
Child Support – Case Payment History	\$ _____	
Social Security (SSI/SSA) – Award Letter	\$ _____	
Disability Income – Award Letter	\$ _____	
Unemployment – Notification Letter	\$ _____	
Food Assistance/Cash Assistance – Award Letter	\$ _____	
Tribal Money – Award Letter	\$ _____	
Housing Assistance – Award letter/notice	\$ _____	
Student Awards/Grants – Letter	\$ _____	
Other: _____	\$ _____	
TOTAL:	\$ _____	

For Y Staff:
 Staff Initials: _____ Branch: _____
 Documentation provided and attached to application?
 Yes: _____ No: _____
 Date Received: _____



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Household Size	Receive 35% reduced rate if gross household income is less than:	Receive 25% reduced rate if gross household income is less than:	Receive 15% reduced rate if gross household income is less than:
1	\$25,107	\$30,107	\$35,107
2	\$33,284	\$38,284	\$43,284
3	\$41,461	\$46,461	\$51,461
4	\$49,638	\$54,638	\$59,638
5	\$57,815	\$62,815	\$67,815
For each additional family member add:	\$ 8,177	\$ 8,177	\$ 8,177

IV. If your income level is above the limits stated in the chart above, but the regular price is beyond your ability to pay due to extenuating circumstances, please explain below. An example of special circumstances may include medical expenses. In such a case you may be required to provide proof of medical bills paid out of pocket for the amount you are over the limit to qualify. This would not include medical insurance premiums for the current year.

NOTE: Financial Assistance will not apply to Programs or Childcare until the application is approved. Assistance cannot be applied retroactively. Applications can take up to two weeks to process, or longer if the application is incomplete. You will be notified by email or mail regarding the status of your application.

I hereby certify, under penalty of perjury, that the information that I have provided is true and correct as of this date to the best of my/our knowledge. I authorize the Y and their assigns to have access to all financial records necessary to verify the information contained in this application. I agree to notify the Y within 10 working days of any changes of circumstances regarding information contained in this application; otherwise, this Financial Assistance is valid through April 30, 2020. I agree to respect and follow all Y policies and procedures.

Signature _____ Date _____

Return application and verification/support documents to:

YMCA of the Inland Northwest
1126 N Monroe
Spokane, WA 99201
Phone: 509-777-9622 Fax: 509-343-4096
Email: ymca@ymcainw.org
Attention: Corporate Business Office

**The Y: We're for youth
development, healthy living, social
responsibility**

Additional information about the YMCA can be found on our website: ymcainw.org