Need Based Membership Application

The Family Wellness Need Based Membership program matches qualified individuals and families who demonstrate a financial or circumstantial need assistance with a reduced price 6 month membership. To determine the match amount, Family Wellness requires specific information about your financial situation as well as any special circumstance(s) that may warrant additional support.

- Incomplete applications will not be processed until all required documents are submitted.
- Completed applications are reviewed in the order received.
- Family Wellness will reach out to the primary applicant within two weeks to discuss qualifications and level of assistance provided.
- The levels of 75%, 50% and 25% assistance is final and not negotiable.
- Joining Family Wellness with a Need Based Membership will be completed by appointment only.
- Please note we are unable to offer this assistance to college students who have access to fitness centers at the universities, unless applying with dependent children.
- Family Wellness does not allow membership or facility access to persons known to be listed as a registered sex offender.

Complete applications (with all required supporting materials) can be submitted at the Family Wellness front desk, or via email at familywellnessfargo@sanfordhealth.org.

I have read and agree to the above details regarding the purpose, requirements and process of the Need Based Membership offered at Family Wellness.

Printed Name of Applicant: _____

Applicant's Signature: _____ Date: _____/_____/_____

The following items must be submitted in order for the application to be processed:

- Completed Membership Application Form (page 3).
- Documentation from any of the following categories below for you AND anyone within the household.

Please check each of the following verifying you have them

If you are employed: (Check all the apply)

□ At least 4 full weeks (one month) of current pay stubs

□ If you do not receive a pay stub, salary verification, or a letter from your employer must be submitted

□ A copy of your most recent Income Tax Return showing your Annual Gross Income
(1040 – Line 21, 1040ex - Line 6, 1040A Line 15)

If you are unemployed: (Check all the apply)

□ You must submit your State Unemployment documentation

□ If you are receiving Workers' Compensation, please provide document

If you did not file taxes:

□ An Income and Wage Transcript must be presented. Please contact the IRS Tax Assistance Center at www.irs.gov or call 1.800.908.9946

□ If you are self-employed, you must submit your latest business and personal Income Tax Return (Usually located on the top page)

Any additional assistance: (Check all the apply)

□ Verification of Section 8 Housing or other subsidized housing assistance

□ Itemized worksheet showing monthly assistance/income

□ Disclosure of assistance for utility bills

□ Copy of Veteran's Benefit Statement

□ Verification of Alimony, showing the amount received

□ Child Care Assistance

□ Verification of Child Support

□ Social Services Statement /Foster Child payment slip

□ If you are receiving SSI, SSD, TANF, Food Stamps, WIC, Refugee Cash Assistance, General Assistance, Medicaid or Medicare, please submit a copy of the award letter showing the amount received monthly

□ Other Income including rental properties

For each item check marked above, reference your documentation to complete the table below. Fill in the dollar amount for each category for you AND any additional income from anyone within the household contributing to the financial wellbeing for the family.

Household Monthly Income	Primary Member	2nd Adult	Additional Income	SUBTOTAL
Gross Wages, Salaries & Tips				
Social Security & Pensions				
Child Support & Alimony				
Self-Employment/Other				
Federal or State Assistance				
Medical Expenses (provide documentation)				

Year Total Taxable Income*				

Familywellness
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STAFF USE ONLY	
Date Received: _____	Assistance %: _____
Staff Initial: _____	Assistance $: _____
Medical Expenses: Yes or No	

Applicant Information - All fields required

First Name:	Last Name:	MI:
Address:	APT/UNIT:	DOB:
City:	State:	Zip Code:
Phone:	Email:	

Do you or have you had a Y Match Membership at the YMCA of Cass & Clay Counties? □ Yes □ No

Please select the membership type you are applying for: □ Household □ Individual

List all Household members below - Eligible include up to 2 adults living at the same address and their dependent children through the age of 23.

First Name	Last Name	DOB	Gender	Relationship	Will be on Membership
					Yes or No
					Yes or No
					Yes or No
					Yes or No
					Yes or No
					Yes or No
					Yes or No

Why are you interested in a Need Based Membership at Family Wellness? Please share any special circumstance(s):

_____

_____

_____

Please read before signing: I must submit a copy of any income listed on page 2 as well as a completed membership application to be considered. I understand that all applicants must submit required income verification as stated above to be considered for a Family Wellness Need Based Membership. I sign on behalf of all participants listed on the membership application to abide by the Family Wellness Code of Conduct. In completing this application and signing it, I certify that all the information supplied to Family Wellness is true, accurate and complete to the best of my knowledge. **Applications submitted without required supporting materials will not be considered.** I understand that Need Based Memberships expire after six (6) months and if I wish to apply for the Need Based Membership after expiration, I need to resubmit my application with updated income verification.

Primary Applicant's Signature: _____ Date: _____/_____/_____