

MONTHLY HOUSEHOLD INCOME

To determine the level of assistance, Family Wellness requires specific information about your financial situation as well as any special circumstance(s) that may warrant additional support. Fill in the monthly income dollar amount for each category.

Primary: Gross Wages, Salaries & Tips \$	Federal or State Assistance (Examples: SNAP, WIC, Childcare, Medicaid, Rent/Housing, etc.) \$
Spouse/Partner: Gross Wages, Salaries & Tips \$	Medical Expenses \$
Social Security & Pensions \$	Other (Examples: Student Loans, Grants, Family/friend contributions, etc.) \$
Child Support & Alimony \$	Total Income \$

Please share any special circumstances that may not be demonstrated in your application or supporting materials that you would like considered with your application.

PLEASE READ BEFORE SIGNING:

- Documents showing your current financial situation are required to be attached to your application.
- Applications that are submitted without supporting financial documentation will be considered incomplete and will not be accepted.
- Applicants will have 30 days in which to respond to the level of assistance. Failure to accept within 30 days will result in your need to re-apply.
- Family Wellness reserves the right to decline assistance.
- Joining Family Wellness with a Need Based Membership will be completed by appointment only.
- Family Wellness is unable to offer assistance to college students who have access to a fitness center at their university unless applying with dependent children.
- Family Wellness is unable to offer assistance to members that receive financial aid at the YMCA of Cass & Clay Counties.
- 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.
- Family Wellness does not allow membership or facility access to persons known to be listed as a registered sex offender.
- 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.

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