



**FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY**

**ALWAYS
HERE FOR
YOU**

**Scholarship Program
ASHLAND AREA YMCA**



The **ASHLAND AREA YMCA** is a Christian based, not-for-profit, health and human services organization committed to helping people reach their full potential in spirit, mind and body. We are here to serve people of all ages, backgrounds, abilities and incomes. The YMCA is community-based and believes that its programs and services should be available to everyone. That's why the ASHLAND AREA YMCA offers the scholarship program. This program offers a sliding scale that is designed to fit each individual's financial situation.

Scholarship memberships are made possible by funds from the United Way and through the generosity of our members and donors in the Building Strong Families annual fundraising campaign. The YMCA believes a strong sense of ownership and pride is developed if the recipient has contributed to the cost of their YMCA involvement; therefore, adults will be asked to pay some portion of the fees.

Is this a renewal? _____ Yes _____ No Date of application: _____

For what type of membership are you applying? (CHECK ONLY ONE)

_____ Basic Adult _____ Basic Family _____ Single Health Center _____ *Family Health Center

_____ *Family HC/Mother or Father ****Doctor Prescription required for Health Center****

Your Information:

Name: _____ Birthdate: _____

Address: _____ Phone: _____

City, State, Zip: _____ Place of Employment: _____

Spouse's Information: (If Applicable)

Name: _____ Birthdate: _____

Place of Employment: _____ Phone: _____

Name(s) of dependent children living in household:

1. _____ Age _____ Birth date ____ / ____ / ____
2. _____ Age _____ Birth date ____ / ____ / ____
3. _____ Age _____ Birth date ____ / ____ / ____
4. _____ Age _____ Birth date ____ / ____ / ____
5. _____ Age _____ Birth date ____ / ____ / ____

Applications will not be processed until the following is completed:

1. Complete and sign the entire application
2. Please provide one or two of the following: **
 - a. _____ Most recently prepared Federal Income Tax Return, or;
 - b. _____ Bank statements from the previous two (2) months, or;
 - c. _____ Pay stubs from previous two months, or;
 - d. _____ Current SSI benefits verification letter or payment stub, or;
 - e. _____ Documentation of any federal assistance like food stamps, rent subsidy, or Aid to Dependent Children cash assistance, or;
 - f. _____ Copy of unemployment income.****Please provide the following if applicable...**
 - g. _____ Copy of court order awarding child support or alimony, maintenance, etc.
3. If you are applying for use of the health center, you must have a prescription for the health center facilities included in this application filled out and signed by your attending physician.

Gross Monthly Household Income

	Head of Household	2nd Adult In Household
Employment	_____	_____
Unemployment	_____	_____
Child Support	_____	_____
Alimony	_____	_____
Social Security	_____	_____
Food stamps	_____	_____
Retirement Income	_____	_____
Other	_____	_____
Total	_____	_____

*Any other information you want us to be aware of (including extraordinary expenses and/or circumstances)?

ATTENDING PHYSICIAN STATEMENT

PLEASE HAVE YOUR PHYSICIAN FILL OUT THE FORM BELOW ONLY IF YOU ARE APPLYING FOR THE HEALTH CENTER FACILITIES:

NAME: _____ **DATE OF BIRTH** ____/____/____

Dear Attending Physician,

The patient listed above is applying for a reduced membership to the Ashland Area YMCA. They are also requesting access to the Health Center facilities. The Health Center facilities are more expensive and elite. The only things available in the Health Center facilities that are not available in the other areas of the YMCA are the sauna, steam room and whirlpool. The regular YMCA memberships include the gyms, tracks, weight room, treadmills, stairmasters, exercise bicycles, aerobic classes and racquetball courts.

If you believe your patient has a medical condition warranting the use of the sauna, steam room or whirlpools answer the questions below. The whole application will be reviewed and a decision will be made based on the need of the person applying and the availability of the memberships.

How long have you been treating this patient? _____
Do you believe your patient has a medical condition requiring the use of the sauna, steam room or whirlpool? _____
Patients Medical Condition: _____
How will the sauna, steam room or whirlpool benefit this patient? _____ _____
Can this patient benefit from Physical or Occupational Therapy and get this same result or better result than the use of a membership to the YMCA? _____

Attending Physician (Please print) _____
Date

Office Mailing Address _____
Phone

City, State, Zip _____
Attending Physician Signature

* Additional copies of this form are available upon request

Please state your reason and/or circumstances for requesting financial assistance: _____

Have you (or your spouse) ever been arrested or convicted of a felony crime? _____

If yes to above, please explain: _____

By signing below I authorize the YMCA to conduct a background check and/or Sexual Offender Registry.

Your signature

Spouse's signature

_____/_____
Date of birth Driver's License #

_____/_____
Date of birth Driver's License #

Please read each statement and initial:

_____ I understand that if approved I must pay my first month payment and activate my membership within sixty (60) days or my application will be discarded.

_____ I understand these memberships are discounted based on my household size and income.

_____ I understand that if approved I must make the monthly payment each month or the membership will be terminated and I may not reapply until the membership has been paid.

_____ I understand that if approved I must make the payments whether I use the YMCA or not.

_____ The information I am submitting is true and correct to the best of my knowledge.

_____ I understand there is no guarantee that I will be approved for the reduced membership and there is no guarantee that I will receive the Health Center facilities even with a prescription.

Print name: _____

Date: ____/____/____

Signature: _____

**Please return completed application with all documents attached to:
Ashland Area YMCA
Missy Griffith. Membership & Marketing Director
3232 Megan Neyer Way~Ashland, KY 41102**