FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

YMCA CAMP LAKEWOOD
13528 State Highway AA, Potosi, MO 63664
Phone: 573-438-2155
Fax: 573-438-3913
www.camplakewood.org

2020 CONFIDENTIAL APPLICATION FOR FINANCIAL ASSISTANCE

Application Date: _____

Please complete **all of the following questions in full** and attach the necessary documents (photocopies only) and return to your branch of the Gateway Region YMCA. Balance of the allocation must be paid in full or on a monthly basis. **Please print.**

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Age: _____ Birthdate: _____

E-Mail Address: _____

Place of Employment: _____

Position: _____ How long: _____

Work Phone: _____ Cell Phone: _____

Emergency Contact Name: _____ Phone #: _____

Have you ever applied for financial assistance before at the YMCA? ☐ Yes ☐ No If yes, which YMCA?: _____

Single Parent Household? ☐ Yes ☐ No

Spouse/Child(ren) Names	Age(s)	School/Employer	Birth Date(s)

Application for financial assistance is for:

☐ Membership ☐ Individual ☐ Family
☐ Program/Camp ☐ Child Care*
☐ Other: _____

*If this application is for child care/camp, you must have been denied benefits from the Division of Family Services. Please attach your denial letter with this application. Your application cannot be processed until you submit a denial form. If you have applied for benefits and have been put on a waiting list, you must show proof of waiting-list status.

Your present gross (before taxes) income level is:

☐ Under $8,000
☐ $8,001-$9,000
☐ $9,001-$10,000
☐ $10,001-$12,000
☐ $12,001-$14,000
☐ $14,001-$16,000
☐ $16,001-$18,000
☐ $18,001-$20,000
☐ $20,001-$22,000
☐ $22,001-$24,000
☐ $24,001-$26,000
☐ $26,001-$28,000
☐ $28,001-$30,000
☐ Over $30,000

What is the dollar amount that you are willing to pay or have the ability to pay?

Membership: $_____ per mo. Program: $_____ per mo. Child Care: $_____ per mo.

What benefits do you see in having this financial assistance to join the YMCA as a member or participant?: _____

_____

Why are you applying for financial assistance?: _____

_____

ITEMIZED INCOME	
Wages, salaries, tips	$
Unemployment Compensation	$
Social Security compensation	$
Child Support	$
State subsidized funding	$
401K/retirement funds	$
Alimony	$
Other:	$
TOTAL INCOME*	$ 0

**Please explain any extenuating circumstances*

NOTICE TO APPLICANTS

It is the policy of the Gateway Region YMCA to provide services for any person who desires to participate and understands the benefits of the YMCA, regardless of their ability to pay the standard membership or program fees. Those not able to pay the full fee may be awarded assistance, based on their demonstrated need. Funds for financial assistance have been made available through generous contributions. Both subjective and objective criteria are factored into assistance decisions. The YMCA believes that ownership and pride are best developed when recipients of financial assistance contribute to the cost of their YMCA involvement. **Thus, all eligible recipients will be asked to pay a portion of the membership/program fees.** DFS recipients will be responsible for payment of balance of fees not covered through DFS. To maintain eligibility of financial assistance, the recipient must reapply by the expiration on their scholarship assistance letter.

Total household income must be verified at each renewal. Proof of income must be furnished by: (1) LATEST FEDERAL TAX RETURN with W2's attached (if applicable) and/or (2) If tax return has not been filed, LETTER FROM GOVERNMENT AGENCY FORM 1722 must be provided. The scholarship cannot be processed without the income verification.

Applications must be completed in full and are processed in the order they are received. Notification will be mailed to you as to what you quality for within 2 weeks or receiving the application. Upon completing this application and signing it, I certify that the information supplied therein is true, accurate and complete to the best of my knowledge and have read, understand and agree with the YMCA Financial Assistance policies.

Falsification of any information for consideration of financial assistance will result in the YMCA to immediately revoke any granted assistance.

Applicant Signature: _____ Date: _____

. . . . . .

YMCA STAFF USE ONLY

Appraisal conducted by: _____ **Date:** _____

Comments: _____

Amount of assistance granted: $_____

Dear Parent or Guardian:

YMCA Camp Lakewood serves nutritious meals every day. We participate in the Summer Food Service Program, which is funded by the U.S. Department of Agriculture and administered by the Missouri Department of Health and Senior Services.

Our program receives reimbursement for meals served to children meeting the eligibility requirements for free or reduced-price school meals. We must document eligibility by obtaining family-size and income data. If your yearly income is equal to or less than the amount listed below for your family size, your child is eligible for free meals or reduced-price meals. **If your child is a member of a household receiving assistance under the Supplemental Nutrition Assistance Program (formerly known as food stamps) or the Temporary Assistance for Needy Families (TANF) program, he or she is automatically eligible when your case number is listed on the IEF.**

FAMILY SIZE	INCOME-ANNUAL	INCOME-MONTHLY	INCOME-WEEKLY
1	22,311	1,860	430
2	30,044	2,504	578
3	37,777	3,149	727
4	45,510	3,793	876
5	53,243	4,437	1,024
6	60,976	5,082	1,173
7	68,709	5,726	1,322
8	76,442	6,371	1,471
For each additional member add:	+7,733	+ 645	+149

In order to apply for meal benefits, the attached form must be completed according to the directions below:

Part 1: Children Enrolled in the Program
List all of the children in the household for whom the application is made, this includes foster children. Indicate the birth date of each child.

Foster Children: Children whose care and placement is the responsibility of the State or have been placed by a court with a caretaker are eligible for free meal benefits without completing an IEF. You must provide appropriate documentation for verification. You may include a foster child as a household member on the application if also claiming non-foster children.

Supplemental Nutrition Assistance Program (SNAP) or TANF households: If you currently receive benefits from SNAP or TANF please indicate the appropriate case number in the spaces provided and sign and date the form. You do not need to complete Part 2.

Part 2: Household and Income Information
List the names of everyone who lives in your household. Include parents, grandparents, all children, foster children, other relatives, and unrelated people who live in your household. Report the monthly income by source for each household member. The income reported on the application must include all income before deductions.

Part 3: Ethnic and Racial Information -Completion is voluntary.

Part 4: Signature
The adult household member completing the application must sign and date the application. If the household does not receive SNAP or TANF benefits, the adult signing the application must provide the last four digits of their social security number. If the adult does not have a social security number, write "none" in the space provided.

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (800) 795-3272 (voice) or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer.

Sincerely,
Cindy Kean
Food Service Director
573-438-2154

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF COMMUNITY FOOD AND NUTRITION ASSISTANCE
SUMMER FOOD SERVICE PROGRAM

INCOME ELIGIBILITY FORM

To apply for free or reduced-price meal eligibility benefits for your child(ren), please fill out this form and return it to the program

PART 1 CHILDREN ENROLLED IN THE PROGRAM

Complete information below for children enrolled at the camp/site. If child(ren) are receiving Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamp) or Temporary Assistance (formerly AFDC, now funded by TANF), complete Parts 1, 3, and 4 only. Complete Parts 1, 2, 3, and 4 if you did not provide a SNAP case number or Temporary Assistance case number. ***In certain cases, foster children are eligible for free meals regardless of household income. If foster children live in your household, please contact the camp or site sponsor for more information.***

NAME (first and last)	BIRTH DATE	FOSTER CHILD	SNAP CASE NUMBER	TEMPORARY ASSISTANCE CASE NUMBER

PART 2 HOUSEHOLD AND INCOME INFORMATION

List all members of the household including the children listed in Part 1. Indicate source and amount of current income for all members of the household before deductions, such as taxes and social security. Where there are wage earners and self-employed adults, the income of the wage earner cannot be offset by the business losses of the self-employed adult. If last month's income does not accurately reflect your circumstances, you may provide a projection of your current annual income. Irregular self-employed income may be averaged over the prior 12 months.

INCOME BASED ON (CHECK ONE) ☐ YEARLY ☐ MONTHLY ☐ 2 X A MONTH ☐ EVERY 2 WEEKS ☐ WEEKLY

HOUSEHOLD MEMBERS	GROSS WAGES	WELFARE, CHILD SUPPORT, ALIMONY	PENSIONS, RETIREMENT, SOCIAL SECURITY	OTHER

PART 3 PARTICIPANT's ETHNIC AND RACIAL INFORMATION (Optional)

Hispanic or Latino: ☐ YES ☐ NO

Race: ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐ WHITE

PART 4 SIGNATURE

I hereby certify that all information provided is correct and true and that all income is reported.. I understand that this information is being given in connection with the receipt of federal funds, that institution officials may verify information, and that deliberate misrepresentation may subject me to prosecution under applicable state and federal laws.

SIGNATURE OF ADULT FAMILY MEMBER	SOCIAL SECURITY NUMBER XXX-XX-_____	DATE
PRINTED NAME OF ADULT	ADDRESS	PHONE NUMBER

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include the social security number of the adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a SNAP, Temporary Assistance (TA) Program case number for your household or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs. These verification efforts may be carried out through program reviews and investigations, and may include contacting employers to determine income, contacting a SNAP or welfare office to determine current certification for receipt of SNAP or Temporary Assistance benefits, contacting the State employment security office to determine the amount of benefits received and checking the documentation produced by the household member to provide the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported.

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TOTAL HOUSEHOLD SIZE:	INCOME:	INCOME BASED ON (CHECK ONE): YEAR ❑ MONTH ❑ 2 X A MONTH ❑ EVERY 2 WEEKS ❑ WEEKLY ❑	SNAP (Food Stamp) ❑	TEMPORARY ASSISTANCE ❑

Eligibility Determination: ❑ Eligible ❑ Ineligible

SIGNATURE OF CENTER REPRESENTATIVE	DATE