YMCA of Saratoga

Scholarship Application

Date Submitted: ____________

Facility applying for: Full Facility Membership___ Malta____ Corinth____

Please fill out the following information and attach the necessary documents (photocopies only) and return to the YMCA of Saratoga. Completed applications and documents can be mailed to: YMCA of Saratoga, Attn: Scholarship Program Director, PO Box 4610, Saratoga Springs, NY 12866. **Please print clearly and complete front and back pages.**

HEAD OF HOUSEHOLD INFORMATION

Last Name ____ First Name ____ Middle Initial ____ Driver's License Number ____

Street Address ____ Employer ____

City ____ State ____ Zip ____ Work Phone ____

Home Phone ____ Age of Person Listed Above ____ Occupation ____ How Long ____

TOTAL NUMBER OF PERSONS RESIDING IN HOUSEHOLD

A. Total Number of Children ____
B. Total Number of Adults ____
C. Total Persons in Household ☐ (A + B)

MARTIAL STATUS OF PRIMARY ADULT

☐ Single ☐ Married (living w/spouse) ☐ Married (spouse absent)
☐ Divorced ☐ Legally Separated ☐ Widowed

SPOUSE OR CONTRIBUTING ADULT Name ________________________ Age _______

Living in the same household ☐ Yes ☐ No Driver's License Number ____________________

Occupation _______________ Name of Employer _______________________________

Child(s) Name(s)	Age	School	Birth Date
1. ________	____	________	________
2. ________	____	________	________
3. ________	____	________	________
4. ________	____	________	________
5. ________	____	________	________

OTHER INDIVIDUALS LIVING IN THE SAME HOUSEHOLD (roommates, relatives, etc.)

Name ___________________________ Age _______ Relationship ______________________

ARE YOU A CURRENT MEMBER OF THE YMCA of Saratoga ______________

APPLICATION FOR *Scholarship Program* IS FOR: ____

☐ Membership ☐ Program (List ___________) ☐ Child Care* ☐ Other (Please List) _____________

* If application is for child care or camp program, you must first contact Department of Social Services Child Care Assistance to determine eligibility. Please contact Saratoga County DSS Child Care at 884-4283 or 4280.

(over)

MONTHLY ITEMIZED INCOME

Wages, salaries & tips	$ __________
Unemployment compensation	$ __________
Social Security Benefits	$ __________
Child Support	$ __________
State Subsidized Funding	$ __________
Disability	$ __________
Retirement/Pensions	$ __________
Alimony	$ __________
Other: ________________	$ __________
TOTAL MONTHLY INCOME	**$ __________**

Proof of income must be furnished. If you are a full-time student, please attach proof of enrollment.
The Scholarship application cannot be processed without proof of income.

WHAT SHOULD WE KNOW ABOUT YOUR CIRCUMSTANCES AS WE CONSIDER YOUR REQUEST?____

____

HOW DID YOU HEAR ABOUT THE YMCA SCHOLARSHIP PROGRAM? _______________

____

Are you or any family members listed on this membership registered as a Sex Offender at any level in any State? ____

I hereby declare that the information provided is accurate and agree to supply additional information if requested. I understand that falsification of information submitted will result in discontinuation of services provided and could require repayment of full fees. I authorize the YMCA to verify the above information. I understand that Scholarship Program awards may be assessed several times a year. All information provided herein will be kept confidential.

____ ______________

Signature of Applicant Date

For YMCA Office Use Only

_______________	$_______________	$______	________%	$_________
Type of Membership or Program	Cost of Membership or Program	Amount Awarded	Percentage of Fee	Recipient's Portion

_____________________ ____________ Notified by Mail or Phone

YMCA Staff Signature Date of Award (circle one)

Notes:____