

Financial Assistance Membership Application



Primary Member Contact Information :

Name : _____ Date of Birth : _____

Full Address : _____

Phone Number: _____

Secondary Member Information :

Adults (Age 14 and over) who live in the same household	Name	Date of Birth	Relationship	
Children (ages 5-13) who live in the same household <small>*Child must be listed as a dependent on 1040 tax form or must provide proof of custody</small>	Name	Date of Birth	Relationship	

Financial Information :

Membership is never free. Assistance will be based on a sliding income scale.

My household gets money from the following sources. I have combined the income from all adults living with me. My application will be denied if I do not include the required documentation needed.

Source of Income	Monthly Amount	Documentation Required (Only One)
Primary Member Gross income- Salary, wages, and tips before taxes and deductions	\$ _____	<ul style="list-style-type: none"> • 1040 Tax return for each adult in the household <ul style="list-style-type: none"> ◦ Pages 1 and 2 only, cross out social security numbers • Last 30 days of paycheck stubs from each adult <ul style="list-style-type: none"> ◦ Not a bank statement
Secondary Members Gross income- Salary, wages, and tips before taxes and deductions	\$ _____	
Unemployment compensation	\$ _____	
Social Security compensation	\$ _____	
Disability	\$ _____	
Child support	\$ _____	
SNAP	\$ _____	
TANF	\$ _____	
Housing assistance	\$ _____	
Medicare/Medicaid	\$ _____	
401k/Retirement funds	\$ _____	
Total Monthly Income	\$ _____	

I certify that this information is true and complete to the best of my knowledge. I grant permission to the Miller Wellness Center to verify this information. I agree to notify the Miller Wellness Center within 30 days if my financial status should change.

Signature of Applicant: _____ Date: _____

Signature of Staff: _____ Date: _____