

AUBURN YMCA-WEIU  
**YOUTH**  
MEMBERSHIP/PROGRAM SUBSIDY APPLICATION

Revised 3/12/02

YMCA Scholarships are available to boys and girls who are unable to attend the Y or its program because of lack of money. A youth scholarship is a valuable thing to seek, and if received, to be proud of. In every case, the following conditions should be present:

1. Youth is anxious to participate.
2. Youth is cooperative with parents, helpful at home and is making an honest effort to do well in school.
3. Youth is earning money, if possible, to help pay the fee.
4. Parent or guardian is willing to pay as much as possible toward the fee.

Please return the completed application along with last year's income tax statement (If you did not file, attach a copy of your most recent paycheck stub, support or public assistance check) to:

Scholarship Committee  
Auburn YMCA-WEIU  
27 William Street  
Auburn, New York 13021

**PART 1**

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Child's Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone # \_\_\_\_\_ If no phone, how can you be contacted? \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ Sex \_\_\_\_\_

Name of Father, foster father or guardian living here: \_\_\_\_\_

Place of Employment \_\_\_\_\_ Occupation \_\_\_\_\_ Phone # \_\_\_\_\_

Name of Mother, foster mother or guardian living here: \_\_\_\_\_

Place of Employment \_\_\_\_\_ Occupation \_\_\_\_\_ Phone # \_\_\_\_\_

Household Unit: Number of adults over 18 \_\_\_\_\_ Number of Children \_\_\_\_\_

List ages of children \_\_\_\_\_

Please explain briefly why you are requesting subsidy and how the scholarship will benefit your child. \_\_\_\_\_

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Type of membership or program applying for? \_\_\_\_\_

How much can you afford to pay? \_\_\_\_\_

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If applicable, Agency making referral \_\_\_\_\_

Agency Representative \_\_\_\_\_ Phone \_\_\_\_\_

**Part II**

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A. Is this application made for medical reasons? ( ) No ( ) Yes  
If yes, list medical condition: \_\_\_\_\_  
Doctor's Name \_\_\_\_\_ Phone \_\_\_\_\_

B. Are you receiving a Family Assistance Cash grant through the Department of Health and Human Services? ( ) Yes ( ) No If yes, you may be eligible for partial assistance.  
Please list your case worker's name \_\_\_\_\_ and your case number \_\_\_\_\_

C. Please list gross monthly household income and expenses:

Gross Monthly Income:

Monthly Expense:

Wages \$ \_\_\_\_\_  
Public Assistance \_\_\_\_\_  
Food Stamps \_\_\_\_\_  
Support \_\_\_\_\_  
SSI \_\_\_\_\_  
Pension \_\_\_\_\_

Rent/Mortgage \_\_\_\_\_  
Utilities \_\_\_\_\_  
Food \_\_\_\_\_  
Insurance \_\_\_\_\_  
Medical \_\_\_\_\_  
Clothing \_\_\_\_\_

Other (explain) \_\_\_\_\_  
\_\_\_\_\_

Other (explain) \_\_\_\_\_  
\_\_\_\_\_

Total Household Income \$ \_\_\_\_\_

Misc. \_\_\_\_\_  
Total Expenses \$ \_\_\_\_\_

D. References:

1. Name \_\_\_\_\_ Address \_\_\_\_\_  
Phone Number \_\_\_\_\_ Place of Work \_\_\_\_\_

2. Name \_\_\_\_\_ Address \_\_\_\_\_  
Phone Number \_\_\_\_\_ Place of Work \_\_\_\_\_

3. Name \_\_\_\_\_ Address \_\_\_\_\_  
Phone Number \_\_\_\_\_ Place of Work \_\_\_\_\_

E. I, \_\_\_\_\_, do hereby attest that the information given is correct to the best of my  
I understand that all information will be kept confidential. I also understand that some portion of the fee(s) must be paid  
by the applicant and that the membership or program subsidy is good only for the time period stated on the contract.

Date: \_\_\_\_\_ Signature \_\_\_\_\_

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**FOR COMMITTEE USE ONLY**

**PART III**

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Date received \_\_\_\_\_

Program or Membership \_\_\_\_\_ Total Fee: \$ \_\_\_\_\_

Session/Dates \_\_\_\_\_ Family Pays: \$ \_\_\_\_\_

Approved ( ) Yes ( ) No

Requested from  
Committee: \_\_\_\_\_

Notification \_\_\_\_\_ Date: \_\_\_\_\_

Comments: \_\_\_\_\_