KITTERY
COMMUNITY CENTER
The art of active living.

APPLICATION FOR COMMUNITY CENTER PROGRAM ASSISTANCE

APPLICANT: _____

ADDRESS: _____

SOC. SECURITY # _____TEL #_____EMAIL_____

WHAT PROGRAM ARE YOU REQUESTING ASSISTANCE WITH AND FOR WHOM?

_____

WHAT DOLLAR AMOUNT ARE YOU REQUESTING_____

WHAT DOLLAR AMOUNT ARE YOU ABLE TO CONTRIBUTE _____

PLEASE LIST **ALL MEMBERS** OF YOUR HOUSEHOLD:

NAME RELATIONSHIP TO YOU DOB

A. _____

B. _____

C. _____

D. _____

E. _____

PLEASE LIST THE NAMES OF **ALL** EMPLOYED INDIVIDUALS, INCLUDING YOURSELF, WHO RESIDE AT YOUR RESIDENCE.

INDIVIDUAL #1:

Name:_____

Place of Employment: _____

Full or Part time: _____ Hours per week: _____ Hourly Rate: _____

INDIVIDUAL #2:

Name: _____

Place of Employment: _____

Full or Part time: _____ Hours per week: _____ Hourly Rate: _____

INDIVIDUAL #3:

Name: _____

Place of Employment: _____

Full or Part time: _____ Hours per week: _____ Hourly Rate: _____

WHAT IS THE **TOTAL ANNUAL NET INCOME** COLLECTIVELY FOR ALL MEMBERS IN THE HOUSEHOLD?_____

DO YOU OWN YOUR OWN HOME OR PAY RENT? MONTHLY PAYMENT: _____

DOES YOUR CHILD RECEIVE FREE OR REDUCED LUNCH AT SCHOOL? _____

SOURCES OF INCOME:

GROSS MONTHLY SALARIES BEFORE TAXES: $_____

MONTHLY CHILD SUPPORT RECEIVED: $_____

OTHER INCOME (Roommate, etc.) $_____

ASSISTANCE FROM THE STATE OF MAINE: $_____

TOTAL MONTHLY INCOME: $_____

Please include proof of all household income with this application. Attach four (4) weeks of recent pay stubs and a copy of your most current W-2. Your application will be ***deemed incomplete*** if the documentation above is not provided.

Your application and documentation will be kept confidential

Please provide as much information regarding your situation as possible so that a complete portrayal of your circumstances is clearly understood. Attach a separate sheet if necessary. It is recognized that this process is difficult, personal and sensitive, however, the information is essential for a decision to be determined. The Kittery Community Center pledges to provide you with the utmost respect, dignity and sensitivity while doing our best to assist you through the process.

NOTE: Any unpaid balances from prior scholarships awarded must be paid in full before additional scholarship money will be awarded.

AUTHORIZATION TO DISCUSS AND OBTAIN INFORMATION PERTAINING TO THIS APPLICATION FOR FINANCIAL ASSISTANCE.

I, _____ with my residence at _____
Hereby authorize the Kittery Community Center to discuss and obtain information pertaining to me and my family from any agencies, departments and the General Assistance Office that provide assistance to me and/or my family members if needed to process my application. I understand that this information will be kept confidential and only used when necessary to assist my family or me.

YOUR SIGNATURE BELOW IS VERIFICATION THAT ALL INFORMATION IN THIS APPLICATION IS COMPLETE AND FACTUAL.

_____ _____
SIGNATURE OF APPLICANT DATE

If you DO receive financial assistance, we ask that you show your appreciation by writing a letter to York Hospital thanking them for their generosity in donating money to the Kittery Community Center to be used for financial assistance. You may remain anonymous if you wish.

York Hospital 15 Hospital Drive York, ME 03909 Attn: Jud Knox, President