



**FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY**

FINANCIAL ASSISTANCE PROGRAM TWIN PIKE FAMILY YMCA

The Twin Pike Family YMCA is a not-for-profit health and human services organization committed to helping people grow in spirit, mind and body. YMCAs are here to serve people of all ages, backgrounds, abilities and incomes. The YMCA is community-based and believes that its programs and services should be available to everyone. That's why the YMCA offers a FINANCIAL ASSISTANCE program. The program is a sliding fee scale designed to fit each individual's financial situation.

Over the years, we have found that the Financial Assistance program is most utilized by:

- Youth referred by schools, churches and organizations
- Adults who are temporarily out of work
- Adults who are divorced and experiencing financial hardships
- People on fixed incomes
 - People who are overwhelmed by medical bills
 - People experiencing other financial hardships

The YMCA requires individuals provide the requested information on the attached form regarding income, family size and necessary expenses so we can provide assistance in a fair and consistent manner.

To process your application, please provide proof of the following information:

- Last year's W-2 forms for all employed household members.
- Last year's tax forms for all employed household members.
- Current total monthly income amount for all employed household members.
- Current pay stub—dated within ten [10] days [1 month's worth]
- And we need total monthly income numbers for the following, should you receive any of it:
 - Child Support / AFDC
 - Rent Assistance / Housing
 - Food Stamp Assistance
 - Social Security Assistance
 - Unemployment
 - Any other financial support, student loans or any other types of assistance

Note If you do not have a copy of your tax return, you may obtain one by calling the Internal Revenue Service at 1.800.829.1040. If you did not file taxes last year or if you don't have the other documents required, please submit a letter explaining your personal situation.

Please allow five to ten [5–10] days to process your application depending on the branch at which you apply. After this period, you will be notified by mail if your application has been approved or if you need to submit additional information.

All YMCA members receive the same membership benefits, regardless of whether or not they are receiving assistance. YMCA members can feel great knowing they are involved in an organization that cares greatly for the health and well being of people and is committed to building strong kids, strong families and strong communities.

Financial Assistance applicants may re-apply on a yearly basis.



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Twin Pike Family YMCA– Financial Assistance

The Twin Pike Family YMCA offers quality, affordable programs and services designed to benefit people of all incomes and backgrounds. Thanks to many generous community supporters, our Annual Campaign and the United Way, the YMCA is accessible to everyone in the community through financial assistance. All records are kept confidential. Assistance is available for YMCA programs and/or membership. A sliding scale is used to determine how much assistance is awarded.

Eligibility:

1. Membership and program assistance is evaluated on an individual basis depending upon demonstrated financial need. The family income guidelines developed by the Twin Pike Family YMCA will determine initial eligibility. Subjective factors such as recent loss of employment, healthcare issues or other extenuating circumstances are also considered with substantiating documentation. If desired, a meeting can be scheduled with a member service representative. All discussions and paperwork are kept confidential.
2. In order to be considered eligible for financial assistance, each applicant must complete the attached assistance form and submit proper documentation. Applications which are not complete will delay the process until all necessary paperwork is submitted. Total supporting income and support must be provided. Verification of Household Income Adults in the Household, whether they choose to be on the membership or not. Falsification or non-disclosure of any item will result in denial of assistance or immediate termination of already awarded assistance.
3. The support for financial assistance comes from contributions through our Annual Campaign. The awards far surpass the funds raised and in an effort to support as many requests as possible, each recipient is asked to pay some portion of the membership or program/activity fees. These payments are in accordance with our guidelines.
4. Eligibility for financial assistance must be renewed on an annual basis with new application and supporting documentation. Should your financial situation change during the course of your assistance, one may request a review by writing a letter explaining the situation and providing documentation to verify the change in income or circumstances.

Note to Applicants:

1. **Contact your local branch**-if you have questions or need clarification.
2. **Total household income** is verified annually by current income tax returns. If income tax was not file for the past year, a "1722" letter verifying "Non-Verification of Filing Status" must be included. If unemployed but not yet receiving payments, include a letter from the state regarding the status of the claim. Non-US citizens must provide a copy of their Visa.
3. **Processing Period:** There is a maximum of a 14 day processing period for completed applications, and at high volume times additional days may be needed. Please hold your phone inquiries about status until the 14 days have passed. For those turning in additional information the 14 days starts when all necessary documents are received. Should there be circumstances which cannot be made clear with the submitted paperwork a personal interview can be arranged with your member service representative. Please contact your local branch if you have concerns regarding this process.
4. **Please submit copies** and keep your originals. We can make copies if necessary.
5. **Method of Payment:** Once all the data is compiled you will receive a phone call or award letter in the mail which will have an expiration date. Please come in and set up your membership or program as soon as possible. Bring in your photo ID, payment for the first month and billing method. The best source is your personal checking or savings account. The options for payment are: monthly draft or payment in full for the year.

| Item | Description | Source |
|--|---|--------------------------------|
| W-2's | Copies of 2 months most recent pay stubs for all adults. Only if there is a significant change in income & to verify individual income for those filing jointly. | Current employer |
| Letter of Non-Filing | If taxes were not filed | IRS website or office |
| Change in income from last year | | Current employer |
| Copies of all subsidy letters received for anyone in the house | Social Security of SSI Disability | Social Security Administration |
| | Division of Family Services, Food Stamps, Foster Care support, Section 8 or any housing support, Temporary assistance | Division of Family Services |
| | Utility assistance | Housing Authority |
| | Unemployment disbursements | Unemployment web site |
| | Maintenance support | Divorce Decree |
| Other Income | Family support | Letter from their family with |
| | Portfolio Statement with disbursements | Financial Advisor or investor |
| | Pensions | Fund manager |
| | School Grants | School Registrar |
| | Inheritance | Estate disbursing agent |
| Still married, not living together | Copy of separation agreement, or if none both incomes need to be verified by taxes & subsidies and impact your financial situation, usually Medical | IRS, Attorney |
| Proof of dependency | Tax return should have dependents listed, if not on return, then a birth certificate and a letter from the school with the parents name, child's name. Divorce Decree with dependents names and custodial & tax arrangement | |

Our Mission: To put Christian principals into practice through programs that build healthy spirit, mind and body for all.

CONDITIONS OF FACILITY ACCESS

The Y reserves the right to cancel a membership at any time. Any member, guest, or applicant whose actions are not deemed to be in the best interests of the organization may have their membership or application denied.

MEMBER'S RESPONSIBILITY IN CONNECTION WITH USE OF THE FACILITY: You (each member of your family and all guests) should consult with a physician before using our services and facilities. You agree that you will not use the facilities with any medical condition, including open cuts, abrasions, sores, infections, maladies or inability to maintain personal hygiene, if such condition poses a direct threat to yourself or to others. Failure to comply with this agreement could result in suspension or termination of membership privileges.

ASSUMPTION OF RISK: You (each family member and guests) agree that if you engage in any physical exercise or activity, or enter the premises of the branch you do so at your own risk. This includes, without limitation, your use of the locker room, any pool, whirlpool, sauna, steam room, or any equipment within the branch and your participation in any activity, class, program or instruction as well as your use of or presence on the parking area or sidewalk. You agree that you are voluntarily participating in these activities. You assume all risk of injury or the risk of contraction of any illness or medical condition that might result, or any damage, loss or theft of any personal property.

WAIVER AND RELEASE OF LIABILITY: In return for use of the facilities of or entry on the premises of the branch, you agree on behalf of yourself (and each family member and guest) to not sue and to release from any and all liability the Twin Pike Family YMCA (and our affiliates, employees, agents, representative, successors and assigns) from any and all claims or causes of action (known or unknown) arising out of negligence of the Twin Pike Family YMCA. This waiver of release and liability includes, but is not limited to, injuries which may occur as a result of (a) Your use of any exercise equipment or facilities, which may malfunction or break; (b) Our improper maintenance of any exercise equipment or facilities, which may malfunction or break; (c) Our NEGLIGENT instruction or supervision; (d) Your slipping and falling while in the branch or on the premises including parking areas and sidewalks. By participating in the YMCA Nationwide Membership Program, I agree to release the National Council of Young Men's Christian Associations of the United States of America, and its independent and autonomous member associations in the United States and Puerto Rico, from claims of negligence for bodily injury or death in connection with the use of YMCA facilities, and from any liability for other claims, including loss of property, to the fullest extent of the law.

INDEMNIFICATION AND HOLD HARMLESS: You further agree that You WILL INDEMNIFY AND HOLD HARMLESS THE YMCA OF TWIN PIKE FAMILY YMCA, THEIR OFFICERS, AGENTS, AND EMPLOYEES, from any loss, liability, damages or cost of any kind that THE YMCA may incur as the result of any injury to yourself or to any member of your family even if it is contended that any such injury was caused by NEGLIGENCE of the part of the Twin Pike Family YMCA.

SEX OFFENDER REGISTRY: The YMCA conducts regular sex offender screenings on all members, participants, and guests. If a sex offender match occurs, the YMCA reserves the right to cancel membership, end program participation, and remove visitation access.

Primary Adult (printed name)

Signature

Date

Additional Adult (printed name)

Signature

Date

I (We) authorize and request the Twin Pike Family YMCA to charge my (our) checking/savings or credit card account for my (our) monthly fee and, if checked below, for monthly donations to the YMCA Annual Campaign. I (We) further authorize the financial institution to process these fees. I (We) understand fees are non-refundable and non-transferable. I (We) understand charges are continuous. If, for any reason, a payment is not honored by the financial institution, a service fee will be charged on any returned transaction. I realize I am still responsible for my payment including the service fee applied by the YMCA for each return. This is in addition to any service fee my (our) financial institution may charge. The YMCA will resubmit a returned payment automatically and will notify me (us) with any issues. Two or more returns could result in termination of service. I (We) understand charges are continuous and it is my (our) responsibility to notify the YMCA in person to discontinue my (our) services and automatic payments. **I (We) understand cancellation requests must be submitted in writing on or before the 20th of the month prior to my (our) next draft date.** If I (we) notice a discrepancy on my (our) statement, I (we) will notify the YMCA promptly. I (We) understand refunds are not issued for discrepancies 90 days or more. The Y reserves the right to discontinue service at any time. Any member, guest, or applicant whose actions are not deemed to be in the best interests of the organization may have their membership or application denied.

Payment Authorization Signature (Must be at least 18 years of age)

Date

| | | | | |
|------------------------|---------------------|--------------------------|--------------------------|-----------------------------|
| Member ID | Draft Amount | Joiner Fee | Amount Paid | Financial Assistance |
| Membership Type | Draft Date | Locker Rental Fee | Corporate Partner | YMCA Staff |



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Date _____

To enable us to serve you better please complete this form. Proof of all household income is required before approval can be received. Please tell us briefly about your circumstances [you may write on the back of this application or attach another sheet of paper if necessary]:

Adult 1 Name _____ Male Female Birthday ____/____/____

Home Address _____ Apt # _____ City _____ State _____ Zip _____

Home Phone _____ Email _____

Employer _____ Work Phone _____

Emergency Contact _____ Emergency Contact Number _____

Ethnicity (Check all that apply) Asian African American Native American Caucasian Other

FAMILY INFORMATION

| | | | |
|----------------------|---|-------------|---|
| Adult 2 _____ | <input type="checkbox"/> M <input type="checkbox"/> F DOB _____ | Youth _____ | <input type="checkbox"/> M <input type="checkbox"/> F DOB _____ |
| Youth _____ | <input type="checkbox"/> M <input type="checkbox"/> F DOB _____ | Youth _____ | <input type="checkbox"/> M <input type="checkbox"/> F DOB _____ |
| Youth _____ | <input type="checkbox"/> M <input type="checkbox"/> F DOB _____ | Youth _____ | <input type="checkbox"/> M <input type="checkbox"/> F DOB _____ |
| Youth _____ | <input type="checkbox"/> M <input type="checkbox"/> F DOB _____ | Youth _____ | <input type="checkbox"/> M <input type="checkbox"/> F DOB _____ |

FINANCIAL INFORMATION

| | |
|---|---|
| Adult 1 _____ | Adult 2 _____ |
| Employment Monthly Gross \$ _____ | Employment Monthly Gross \$ _____ |
| Unemployment Monthly Gross \$ _____ | Unemployment Monthly Gross \$ _____ |
| Disability Monthly Gross \$ _____ | Disability Monthly Gross \$ _____ |
| Social Security Monthly Gross \$ _____ | Social Security Monthly Gross \$ _____ |
| Food Stamp Monthly Gross \$ _____ | Food Stamp Monthly Gross \$ _____ |
| Child Support Monthly Gross \$ _____ | Child Support Monthly Gross \$ _____ |
| AFDC/TANF Monthly Gross \$ _____ | AFDC/TANF Monthly Gross \$ _____ |
| Other Monthly Gross \$ _____ | Other Monthly Gross \$ _____ |
| TOTAL MONTHLY GROSS \$ _____ | TOTAL MONTHLY GROSS \$ _____ |

MEMBERSHIP TYPE

Household Single Parent Family Adult Senior Citizen Adult Senior Citizen Couple

If income is below \$400/month, how are you meeting your needs?

I certify the above information on this form is true and correct to the best of my knowledge. I consent to the Twin Pike Family YMCA to verify any and all information on this application.

Date: ____/____/____ Signature _____ Print Name: _____

OFFICE USE ONLY

Annual Income _____ Possible Deductions _____ Program Amount: Member \$ _____
 Number of Dependents _____ % of Co-Pay _____ Non-Member \$ _____
 \$ _____ ACH/Month Scholarship Amount Approval: _____ Expiration Date: _____

1. Why are you applying for Financial Assistance?

2. How will the YMCA and Financial Assistance benefit you and your family?

3. Are there any unique circumstances that impact your financial stance?

4. What volunteer service can you provide to the YMCA?

5. Have you ever been charged or convicted with sexual misconduct/abuse?
Are you required to register as a sex offender?

6. Have you ever been convicted of possession, transportation, or distribution of narcotics or dangerous drugs? (This does not necessarily disqualify you from membership benefits.)

APPLICANT'S SIGNATURE:

DATE:

YMCA STAFF USE ONLY

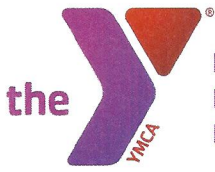
Appraisal conducted by _____ Date _____

Comments: _____

Amount of assistance granted _____% Value of Scholarship \$ _____

Date notified: _____ Date of entry to GP _____

Staff initials _____



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Last Name, First Initial _____ **Member ID** _____

How to apply for Financial Assistance:

- Turn in application, financial verification and dependent verification to the YMCA Welcome Center.
- Your application **will not** be accepted unless required verification is submitted in its entirety.
- Applicants will be notified of the decision within 10 business days of applying.
- Approved applications will be kept on file for 60 days. If unclaimed, please re-apply with most up to date information.
- You may renew your membership annually by following the same guidelines and submitting a letter stating how this program has affected you and or your family.
- The Y should be notified if there is a change in income/household status. This may result in a fee adjustment.
- If you have extenuating circumstances that you wish to explain please attach a letter.

| Documents | Member Initials | Staff Initials upon receipt |
|---|-----------------|-----------------------------|
| Completed Membership/Program Application in its entirety; signed and dated | | |
| Most recent Federal tax form ex. 1040, 1040ez, for Seniors or persons receiving Disability form must be attached. | | |
| Documentation of all Household Income: monthly income, food stamps, social security, alimony, child support, VISA information, etc. | | |
| If applicant is unemployed: Official Unemployment Letter with eligible benefits or Denial Letter | | |
| Documentation of dependents if they are not listed on tax return (under the age of 18) i.e. birth certificate or medical card | | |
| Backside of this form completed in its entirety | | |
| Expectations for renewal eligibility are: <ul style="list-style-type: none"> • 8 visits per household per month in order to renew membership • Program enrollment: during a 7 week session, no more than 3 program absences in order to enroll in the following session | | |
| Membership dues may be paid: <ul style="list-style-type: none"> • On a Bank Draft through checking or savings account • 1 year in advance | | |
| Condition of Facility Access waiver signed | | |

Our Mission: To put Christian principals into practice through programs that build healthy spirit, mind and body for all.

Authorization for Release of Information

Date Faxed: _____

Date Received: _____

To: Pike County MO DFS

Attn: Eligibility Supervisor

Fax: 573-324-2930

From: _____

Twin Pike Family YMCA

614 Kelly Lane

Louisiana, MO

(p) 573-754-4497 (f) 573-754-6330

Subject: Verification of Public Assistance

Re: _____

SSN/DCN: _____

I authorize the Pike County Missouri Division of Family Services to release information to the Twin Pike Family YMCA for the purpose of determining membership and program assistance.

This consent will expire one (1) year from the above date, unless you wish to shorten this consent by entering a specific expiration date in the following field.

Date: _____

Information Being Requested

Rate per Month

Temporary Assistance \$ _____

Food Stamp Benefits \$ _____

Child Support \$ _____

MO HealthNet Benefits \$ _____

Parent/Guardian Signature _____ Date _____

Spouse Signature _____ Date _____

Parent/Guardian Address (Street, City, State and Zip Code)

IMPORTANT INFORMATION REGARDING YOUR APPLICATION FOR CHILD CARE SUBSIDY

Including the following documents when mailing or dropping off a child care application, can assist in processing the application in a timely manner:

Citizenship/Relationship

- Citizenship or Immigration Status – if not a United States Citizen, documentation that verifies your legal status in the United States.
- Birth Certificates – if children are born out of state, original birth certificate from the state/country child was born in.

Income

Both earned and unearned income must be verified for all household members included in the eligibility unit.

- Pay check stubs (at least last 30 days and continuous pay periods)
- If new employment, a letter on company letterhead, from the employer stating the number of hours you will be working during a pay period and how often you will be paid. Should also include the date of your first paycheck
- Social Security/Supplemental Security Income – award letter or other verification from the Social Security Administration.
- Child Support income – can usually be verified through the state computer system; however, if you receive child support from a different state, verification will be needed.
- Self-employment – current tax return along with any supporting schedules that were filed.
- Education – documentation for all grants/scholarships/loans you have received to attend school.

If you are uncertain if something is needed to verify income, it is better to submit all documentation/verification you have.

Need for Child Care

To be eligible for child care, there must be a need for all adults in the household or a documented special need for a child. The following are considered valid needs for child care and the verification needed:

- Employment – a copy of your work schedule from your employer, or a letter from the employer on company letterhead, stating the days and hours each day that you work.
- School – A copy of a class schedule to include times and days of week attended. When a class schedule changes a new one must be submitted.
- Training – if you are enrolled in a training through a local agency/program, a copy of the training schedule with days and hours of attendance
- Incapacitated Care Taker – a physician's statement explaining you are unable to care for your child due to a mental or physical disability
- Child with a Special Need for Care – if you do not have a traditional need for care (employment, school, etc.) but have a child that has been classified as having a special need and that child has a special need for care, a medical professional must submit a statement regarding the reason care is needed and the duration of the need for care.

Child Care Provider Name – If you have chosen the child care provider or facility your child will be attending, please provide the name, address, phone number and/or DVN of that provider.

If you need assistance finding a child care provider, you may contact Child Care Aware of Missouri @ (800) 200-9017 or visit the website at <http://mo.childcareaware.org/>. You may also visit the Department of Health and Senior Services' Show Me Child Care Provider search at <http://health.mo.gov/safety/childcare/>.

Social Security Numbers (SSN)

A SSN is NOT required as a condition of eligibility for Child Care Subsidy. Disclosure of SSN is strictly voluntary and will not affect your eligibility for Child Care Subsidy. Child Care Subsidy cannot be denied because you decide that you do not want to disclose your SSN or the SSN for any household member, including children whom benefits are requested. However, if you are applying for other benefits, along with Child Care Subsidy, your SSN may be required.

CHILD CARE APPLICATION

Need help with your application? Call us at 1-855-373-4636. If you need help in a language other than English, tell the customer service representative the language you need. TTY user can call 1-800-735-2966. If you are blind or visually impaired and would like information regarding Rehabilitation Services for the Blind, please call 1-800-592-6004.

INSTRUCTIONS: List your address and any phone numbers where you may be reached.

| | | | |
|-------------------------------|--|-------|-----|
| Applicant Full Legal Name | | Date | |
| Home address | City | State | Zip |
| Mailing address, if different | City | State | Zip |
| Primary phone number | What kind of phone is this? <input type="checkbox"/> cell <input type="checkbox"/> home <input type="checkbox"/> work <input type="checkbox"/> other | | |
| Alternate phone number | What kind of phone is this? <input type="checkbox"/> cell <input type="checkbox"/> home <input type="checkbox"/> work <input type="checkbox"/> other | | |
| Email Address | Preferred method of contact? <input type="checkbox"/> *call <input type="checkbox"/> text <input type="checkbox"/> email <input type="checkbox"/> mail *We will call your primary phone unless you note otherwise | | |

INSTRUCTIONS: List all persons who live at your address including yourself. List yourself first. Answer all questions about each person.

| Full Legal Name (First, Middle, Last) | Date of Birth | Race | Gender | Marital Status | SSN (Optional for Child Care) | Relationship to Head of EU |
|---------------------------------------|---------------|------|--------|----------------|----------------------------------|----------------------------|
| | | | | | | Head of Eligibility Unit |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

Are the above household members Missouri residents and do they intend to remain in Missouri? Yes No

If no please explain:

INSTRUCTIONS: List all persons who have earned or unearned income in your household.

| Name | Source | Monthly Gross Income | Hourly Pay Rate | Tips Per Pay Period | Pay Frequency |
|------|--------|----------------------|-----------------|---------------------|---------------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Are you receiving other State or Federal assistance? Yes No If yes, explain: _____
 amount: _____

Are any changes in income expected? Yes No If yes, explain: _____
 amount: _____

Do you pay a health insurance premium? Yes No If yes, premium frequency: _____
 amount: _____

Do you pay a dental insurance premium? Yes No If yes, premium frequency: _____
 amount: _____

Do you pay a vision insurance premium? Yes No If yes, premium frequency: _____
 amount: _____

Do you have more than \$1,000,000 in assets? Yes No

Please provide information concerning your child care provider(s) in the areas provided. Under each provider you list, include the information for each child under that provider's care. Please ensure you list the provider's relationship to each child you list with that particular provider (i.e. grandmother, no relation).

| | | | |
|--------------------|------|--------------|-----|
| Name of Provider 1 | DVN | Phone Number | |
| Street Address | City | State | Zip |
| Name of Provider 2 | DVN | Phone Number | |
| Street Address | City | State | Zip |

Is your child(ren) enrolled in Early Head Start or Head Start? Yes No

Please list the number of days per week each child is in care for each category listed below:

| Child's Name (first, middle, last) | Relationship To Provider | 5 or more hours | | 3 to 5 hours | | Less than 3 hours | |
|------------------------------------|--------------------------|----------------------|--|----------------------|--|----------------------|--|
| | | Daytime (6am-6:59pm) | Evening/Weekend (7pm-5:59am) (Saturday/Sunday) | Daytime (6am-6:59pm) | Evening/Weekend (7pm-5:59am) (Saturday/Sunday) | Daytime (6am-6:59pm) | Evening/Weekend (7pm-5:59am) (Saturday/Sunday) |
| 1. | | | | | | | |
| 2. | | | | | | | |
| 3. | | | | | | | |
| 4. | | | | | | | |
| 5. | | | | | | | |
| 6. | | | | | | | |

THE NEED FOR CHILD CARE IS BECAUSE YOU OR A HOUSEHOLD MEMBER IS: (CHECK ALL BOXES THAT APPLY)

- employed? Where _____ Phone Number _____ Name _____
- attending school? Where _____ Phone Number _____ Name _____
- in job training? Where _____ Phone Number _____ Name _____
- being evaluated for training and/or employability? Where _____ Phone Number _____ Name _____
- disabled? Can you care for your child(ren) _____
- I am homeless (Defined as individuals who lack a fixed, regular, and adequate nighttime residence)
- Your child has a "special need" for child care? (i.e. child is classified as having a special need, there is no traditional need for care, but a medical professional has determined the child needs to be in child care.)

- My signature below certifies under penalty of perjury that all information given is true, correct and complete to the best of my knowledge.
- I understand that I am entitled to fair and equal treatment regardless of race, color, religion, national origin, sex, ancestry, age, sexual orientation, veteran status, or disability.
- I agree to provide any additional information or verification that is requested to determine my eligibility within 15 days of application date.
- I agree to report changes in my income if it exceeds 85% of the State Median income.
- I understand that the statements I have made are subject to investigation and verification.
- I also understand that the laws of Missouri provide for fine or imprisonment or both for persons who knowingly receive or attempt to receive public assistance they are not entitled to or who knowingly fail to report information required to determine eligibility for public assistance.

By signing this application on paper or electronically, you are giving us permission to deliver, or cause to be delivered, phone calls to you regarding your case from an automated dialing system at the primary phone number you provided on Page 2. You do not have to consent to this as part of your application. If you want to opt out of getting these calls, check here:

| | |
|---------------------------------|------|
| SIGNATURE OR MARK OF APPLICANT: | DATE |
| WITNESS TO MARK: | DATE |