Financial Assistance Application

All information submitted concerning annual income, family size and assets is subject to verification by Spectrum Health. If the information submitted is determined to be false, this application will be rejected. This application is for Tamarac dues financial assistance.

Contact Information

Application is for: Individual Family

Applicant legal name: _____ Date of birth: _____

Street address: _____ City, Zip: _____

Phone: _____ Email: _____

Are you currently employed? Yes No If unemployed, how long:_____

Family members in household: _____

Total annual household income: _____

Applicant

Most recent employer: _____

Date hired: _____ Last date worked: _____

Annual salary: _____ or

Hourly wage: _____ Average hours per week: ___

Partner

Most recent employer: _____

Date hired: _____ Last date worked: _____

Annual salary: _____ or

Hourly wage: _____ Average hours per week: ___

Additional Members Living in Household

Name	Date of Birth	Relationship	Applying*	
_____	_____	_____	Yes*	No
_____	_____	_____	Yes*	No
_____	_____	_____	Yes*	No
_____	_____	_____	Yes*	No

* Additional application fee must be paid for each applicant for consideration in the program.

Other Sources of Monthly Income (list amounts)

Please submit a copy of your most recent tax return, payroll stubs and other documents listed in the cover letter.

Monthly Income	Applicant	Partner	Dependants/Other
Commission, bonus and/or tips	$ _____	$ _____	$ _____
Social Security	$ _____	$ _____	$ _____
Disability	$ _____	$ _____	$ _____
Public assistance/food stamps	$ _____	$ _____	$ _____
Unemployment benefits	$ _____	$ _____	$ _____
Student loans and grants	$ _____	$ _____	$ _____
Workman's Compensation	$ _____	$ _____	$ _____
Child support	$ _____	$ _____	$ _____
Rental income	$ _____	$ _____	$ _____
Investments	$ _____	$ _____	$ _____
Other income (pensions, benefits, alimony, etc.)	$ _____	$ _____	$ _____

Assets

Please list all account balances at all banks. Use "other" for additional checking, savings, HSA or other accounts.

Account Type	Balance	Bank Name
Checking	_____	_____
Savings	_____	_____
Other: _____	_____	_____

Transporation

Make and Model	Monthly Payment	Balance
Primary vehicle _____	$ _____	$ _____
Secondary vehicle _____	$ _____	$ _____
Motorcycle _____	$ _____	$ _____
Other vehicle(s)*_____	$ _____	$ _____

* Include snowmobiles, boats, trailer, motor home, ATV and any other vehivles applicant owns and has a payment for.

Household Expenses

List applicable monthly payments. Only property taxes are accounted as an annual amount. Please include both summer and winter taxes.

House payment	$ _____/month	Rent	$ _____/month
Property taxes (annual)	$ _____/year	Phones (including mobile)	$ _____/month
Childcare/child support	$ _____/month	Medications	$ _____/month
Health insurance	$ _____/month	Cable/DISH/Internt	$ _____/month
Life insurance	$ _____/month	Trash removal	$ _____/month
Electric	$ _____/month	Groceries	$ _____/month
Gas/propane	$ _____/month	Student loan/tuition payment	$ _____/month
Water	$ _____/month	Other: _____	$ _____/month

Credit Card and Loan Payments

Name of lender/card	Monthly Payment	Balance
_____	$ _____	$ _____
_____	$ _____	$ _____
_____	$ _____	$ _____

Personal Statement

I would like to join Tamarac because:_____

_____

_____

_____

_____

_____

Note: Please use only the space provided and do NOT submit additional personal statement or phsycian referrals. Additional documents will not be considered.

Continue application on page 3.

I affirm to the best of my knowledge that this information is true and accurate. Prior to seeking financial assistance, I have pursued all reasonable forms of third party payment. If accepted, I agree to follow program rules in addition to facility membership rules, regulations, and guidelines.

Signature _____ Date _____

For questions, call (guardian/payee/other) _____ at _____. I am available _____

Disclosure of Personal Health Information
Spectrum Health is commited to protecting the confidentiality of your personal and health information. Spectum Health will not disclose your information without your written authorization. Your information will be used for Financial Assistance Criteria. Spectrum Health may use and disclose your health information for the seamless delivery of services and to document anonymous program outcomes at Tamarac, a member of Spectrum Health. For example, we may use your personal information to interpret your need for participation in our program and to contact you regarding program acceptance or discharge.

Office Use Only
Application received on _____/_____/_____/ by (representative name) _____

SPECTRUM HEALTH

Tamarac's Financial Assistance Eligibility Summary

The financial assistance program was developed to benefit community and Tamarac members who are unable to pay for their membership and desire to continue a healthy, active lifestyle. Applications may be submitted in person at Tamarac or online at **tamaracwellness.org/financialassistance**.

Members granted financial assistance will be responsible for a minimum monthly payment set by the financial assistance review committee. In addition, program members must complete the following to remain eligible for continued financial assistance:

- Attend an enrollment meeting
- Schedule an initial appointment with a fitness specialist
- Maintain a minimum of six visits a month
- Undergo a six-month evaluation with a fitness specialist

Application Due Date	**Start of Membership Date** (if approved)
March 1	April 1
June 1	July 1
September 1	October 1
December 1	January 1

Before turning in your application, please make sure you have the following:

- Copy of driver's license
- Copy of tax returns
- Copy of bank statements
- Copy of pay stubs or any proof of income for the past month
- Letter from applicant providing temporary support if no income
- $5 application fee

*Assistance is available if you need help filling out the application.

For more information or questions, call Spectrum Health Gerber Memorial Community Health & Wellness at 231.924.3073 or email communityhealth@spectrumhealth.org.