

Skye High Gymnastics Center - Low Income Discount Program Application

This application is for low income families that are on government assistance or fall within the US Poverty Guidelines. This information will be viewed by multiple parties and needs to be re-submitted every January. Both parents are required to fill out the following information. Information will be processed as a COMBINED total. If both parents are not applicable, you may be asked to answer additional questions following your application. This is for recreational classes only. Discounts will not be available for competitive teams. Scholarships and fundraising may be available for those programs.

Athlete Information

Athlete Name: _____ DOB: _____
Athlete Primary Address: _____
Athlete School District: _____
Does this child receive health insurance assistance (Medicaid)? Y / N
Does this child receive free/reduced lunch if offered at their school? Y / N

Parent Information

PARENT 1 OR PRIMARY GUARDIAN *(Athlete should reside with this person at least 50% of the time.)*

Parent/Guardian Name: _____ DOB: _____
Contact Email: _____ Contact Phone: _____

Residential Address: _____

How many people reside in this household? _____ Is parent 2 included? Y / N

Check all programs that apply:

- | | |
|--|---|
| <input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP)(Food Stamps) | <input type="checkbox"/> Supplemental Security Income (SSI) |
| <input type="checkbox"/> Federal Public Housing Assistance (FPHA) | <input type="checkbox"/> Medicaid |
| <input type="checkbox"/> Veterans Pension or Survivors Benefits Program | |

Employment Company: _____

Employer Name: _____ Contact Phone: _____

Salary/Annual Income (USD): _____

Please list any additional income such as child support, unemployment, or other part time jobs: _____

**By signing below I acknowledge that all of the above information is true and filled out to the best of my ability.*

Signature: _____ Date: _____

PARENT 2 *(this includes step-parent if the original parent is unavailable)*

Parent/Guardian Name: _____ DOB: _____

If this individual is unavailable or does not pertain to the athlete's life, please explain: _____

Residential Address *(if different than above)*: _____

How many people reside in this household? *(Skip if included in parent 1 information)* _____

Check all programs that apply:

- | | |
|--|---|
| <input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP)(Food Stamps) | <input type="checkbox"/> Supplemental Security Income (SSI) |
| <input type="checkbox"/> Federal Public Housing Assistance (FPHA) | <input type="checkbox"/> Medicaid |
| <input type="checkbox"/> Veterans Pension or Survivors Benefits Program | |

Employment Company: _____

Employer Name: _____ Contact Phone: _____

Salary/Annual Income (USD): _____

Please list any additional income such as child support, unemployment, or other part time jobs: _____

**By signing below I acknowledge that all of the above information is true and filled out to the best of my ability.*

Signature: _____ Date: _____