Inclusive Fitness Financial Assistance Application

The IM ABLE Foundation seeks to remove the financial barriers that prevent our community members with physical, cognitive and behavioral challenges from achieving their physical fitness goals. All initial applications will be reviewed in the order that they are submitted and qualified applicants will receive financial assistance when funding is available. Applicants must resubmit for financial assistance by April 1st and October 1st of each year. Applicant's financial information is confidential.

Please read the Required Income Documentation Checklist in its entirety and submit in one complete package in person at the IM ABLE Headquarters, by mail to IM ABLE Foundation, 220 Park Road N, Wyomissing, PA 19610, Attn: Program Director, or by email to Ruthie@imablefoundation.org.

REQUIRED INCOME DOCUMENTATION CHECKLIST

_____Most recent year of Income Tax Returns (for all household members) – 1040 or 1040EZ, as filed with the Internal Revenue Service

_____Two most recent consecutive pay stubs (for all household wage earners), showing gross and net income (if applicable) OR

_____Letter of employment on company letterhead with Applicant's full name, specified salary (gross), signature of employer representative with title, contact number, and date OR

_____Disbursement letter from Social Security Office for annual income verification.

_____Medical Waiver

APPLICANT CONTACT INFORMATION

APPLICANT NAME: _____

HOME ADDRESS: _____

HOME PHONE: _____

CELL PHONE: _____

EMAIL ADDRESS: _____

INSURANCE PROVIDER: _____

APPLICANT'S ANNUAL INCOME

INCOME:	
SUPPLEMENTAL INCOME:	

HOUSEHOLD MEMBERS' ANNUAL INCOME

MEMBER (1) - INCOME:	
MEMBER (1) - SUPPLEMENTAL INCOME:	
MEMBER (2) - INCOME:	
MEMBER (2) - SUPPLEMENTAL INCOME:	

DEPENDENT INFORMATION

DEPENDENTS (NOT already listed):	**NAME**	**AGE**
DEPENDENT (1)		
DEPENDENT (2)		
DEPENDENT (3)		
DEPENDENT (4)		
DEPENDENT (5)		

I acknowledge that the information provided is true and correct. I authorize the facility to verify any information contained in this document for the sole purpose of assessing financial need.

I understand that if my financial situation or availability of resources changes, I am required to notify the facility of the change for the purpose of being reassessed for this program.

Signature of Applicant Date