A W O L A L L W A L K S O F L I F E , I N C .

P.O. Box 15846, Savannah, Georgia 31416 Θ Phone: 912.303.4987 Θ Fax: 912.525.3160 Θ Web: www.awolinc.org

CONFIDENTIAL FINANICAL ASSISTANCE APPLICATION

In order for this application to be considered, all information requested must be completed *AND ALL REQUESTED DOCUMENTATION TURNED IN.* Applications submitted without adequate documentation will be denied.

Date of Application: _____

Participant Name: _____ School: _____ Grade: _____

Male_____ Female _____ Age: _____ Race: _____

Home Address: _____ Home Phone: _____

- Does this child receive FREE or REDUCED price meals at school? Yes ____ No ____
- Does anyone in the household receive Food Stamps? Yes____ No ____
- Does anyone in the household receive Temporary Assistance To Needy Families (TANF) Yes ____ No ____

Parent Guardian Name: _____

Is the Parent/Guardian Employed? Yes_____ No _____

If employed, employers name: _____ Work Address: _____

Total number living in household: _____ Total Household Gross Annual Income: $ _____

Total Household Monthly Income: $_____ Weekly: $_____

Proof of income must be attached to this application.

- ✓ **Copy of 2 most recent pay stubs**

And one of the following additional items:

- ✓ **Verification of income from employer (may use attached form)**
- ✓ **Copy of most recent IRS Tax Return**
- ✓ **Other written proof of income (please specify) _____**

Please write a brief narrative explaining any factors that should be considered in your request financial assistance. Please describe any permanent or temporary hardships that may be affecting your ability to pay the program fees.

_____
_____
_____
_____
_____

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_____
_____
_____
_____

I hereby certify that to the best of my knowledge, the above information given is true and correct. I understand that AWOL Executive staff may verify the information on this application and I do hereby authorize my employer to release this information to AWOL. I understand that deliberate misrepresentation of the information may result in my child's dismissal from the program and/or require that I reimburse the program for any financial aid received. I further understand that the submission of this application does not guarantee the granting of financial aid for my child and that the approval of any financial aid is entirely dependent upon the availability of necessary funds. AWOL reserves the right to re-evaluate this application at any time and discontinue financial assistance based on any changes of circumstances. I understand that a new application must be submitted at the beginning of each school year.

X_____ _____

Signature of Parent/Guardian Date

AWOL All Walks of Life, Inc. dose not discriminate on the basis of race, color, national origin, sex or handicap in educational programs, activities and employment.

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Do not fill in below –**FOR OFFICE USE ONLY**

DATE RECEIVED: _____

APPROVED FOR: $_____ PER MONTH/WEEK APPROVED REGISTRATION FEE: $_____

DENIED-Reason for denial:

_____
_____
_____

_____ _____

Program Assistant Signature/Date Date Notification Sent

_____

Executive Director /Date

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VERIFICATION OF INCOME FORM

Please submit form to your employer. This form must be returned with your application for Financial Assistance.

Employees Name: _____

Annual Gross Income: _____

Monthly Income: _____

Name of Employer: _____

Payroll Department Contact: _____

I certify that to the best of my knowledge, the above information is true and correct. I understand that any misrepresentation by employer or employee will be grounds to cancel any reduced benefits received and/or require that the employee reimburse the program for any financial aid received.

_____ _____

Signature of Employer Date

_____

Title