Inspire Collaborative Health Association

Membership Assistance Application

Personal Information

Name:				Phone:			
Address:		City:		ST:		Zip:	
Email:							

Income		Expense	
Gross Monthly Income (Before Taxes)	$	Rent/Mortgage	$
Spouse's Gross Monthly Income (Before Taxes)	$	Car/Insurance	$
Child Support	$	Fuel	$
Aid To Dependent Children	$	Groceries	$
Social Security Compensation	$	Utilities	$
Unemployment Compensation	$	Phone	$
Food Stamps	$	Child Support	$
Welfare	$	Medical	$
Retirement Funds	$	Child Care	$
Other (Please Explain)	$	Alimony	$
Other (Please Explain)	$	Other (Please Explain)	$
TOTAL MONTHLY INCOME:	$	**TOTAL MONTHLY EXPENSE:**	$

The following may be used to support your membership assistance request:

☐ 1040 Tax Form	☐ Free & Reduced Lunch Letter	☐ Social Security Letter

Additional Items For Consideration (Job Loss, Disability, etc.)

I am requesting assistance from ICHA due to my current personal circumstances. I verify that all information submitted is complete and accurate. If my situation changes, I agree to notify ICHA. If I submit false or inaccurate information, my current and future enrollments could be subject to denial.

I understand that if approved, my membership assistance discount covers one years annual membership due. To extend this discount into next year's annual membership due, I must re-verify my income one month before the end of my annual renewal period.

Applicant Signature: _____ Date: _____

Assistance Approval (Internal Use for ICHA Staff)

Approved By:		Date:		Approved Discount:	☐ 15%	☐ 25%	☐ 35%