

Chippewa Youth Hockey Association

CYHA Partner with Youth Membership Assistance Application

The Partner with Youth program is made possible through funds contributed by local businesses, individuals, and the Chippewa Youth Hockey Association. In order for us to process this application, you must complete the confidential form and return it to the Chippewa Youth Hockey Association in care of the President.

Applicant _____ Date of Birth _____
Spouse _____ Date of Birth _____
Address _____ Phone _____

Are you Married ___ Divorced ___ Separated ___ Widowed ___ Never Married ___

List Children (those that are current members of your immediate household).

Full name	Relationship	Date of Birth	School
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Briefly explain why you are applying for the CYHA Partner With Youth Membership Program

Personal Information

1. Family Income (list all that apply)

- A. Applicant's monthly income _____ Employer _____
- B. Spouse's monthly Income _____ Employer _____
- C. Monthly AFDC Income _____
- D. Monthly Social Security _____
- E. Any other income (child support, etc.) _____

2. Family Expenses

A. Do you own your own home? _____ Monthly payment plus taxes _____

B. Do you rent? _____ Monthly payment _____

C. Do you own a vehicle? _____ Make, year, model _____

D. Monthly medical: Insurance _____ Doctor _____
Hospital _____ Other _____

E. Monthly Utility Payments: Phone _____ Water _____
Electricity _____ Fuel _____ Cable TV _____

F. Other monthly outstanding financial payments _____

3. Do you have a

Case Worker _____ Name _____

Address _____ Phone _____

4. Personal references who are familiar with your situation

Name Address Phone

1. _____

2. _____

3. _____

5. What program/activities would you/your family participate in?

6. Can you afford to pay a monthly payment toward this membership? _____ If yes, how much? _____

I hereby testify that the information on this application is a true and complete statement of facts according to my best knowledge and belief. I authorize Chippewa Youth Hockey Association to contact any of my references for information pertaining to these facts. I understand that I am responsible to notify CYHA of any changes in family or financial status immediately should they occur.

	Signature		Date
OFFICE USE ONLY	_____	CYHA Staff	_____
Type of Membership	_____	Date Accepted	_____
Family Income	_____	Date Notified	_____
Total Family Members	_____	Comments	_____
CYHA/By Request	_____	Monthly Payment	_____
		Expiration Date	_____