Date of Application_____

EASTERN RIO BLANCO METROPOLITAN RECREATION & PARK DISTRICT
REDUCED RATE PROGRAM APPLICATION

Applicant understands that if the applicant is awarded, and accepts, financial assistance from the District, the applicant will have to pay a portion of the fee for any classes in which the applicant wants to register, or any memberships you wish to purchase. Such fee will be due at the time of registration or purchase. Payment plans are available for annual memberships. This application shall constitute the applicant's initial registration form with the District.

Person requesting Reduced Rate (please print):

Name: _____

Mailing Address: _____

Home Phone: _____ Work Phone: _____

Email Address: _____Gender: _____

Date of Birth: _____ Do you have any allergies: Yes ____ No _____

If yes, please list: _____

Emergency Contact information:

Name/Relation: _____ Phone: _____

Please complete the following information for each additional household member. **This information is required.**

Name: _____
Gender: _____
Date of Birth: _____
Do you have any allergies: Yes____ No ____
If yes, please list: _____
_____
Emergency Contact Information:
Name:_____
Relation:_____
Phone: _____

Name: _____
Gender: _____
Date of Birth: _____
Do you have any allergies: Yes_____ No_____
If yes, please list:_____
_____
Emergency Contact Information:
Name: _____
Relation: _____
Phone: _____

Please complete the following information for each additional household member. **This information is required for participation in the District's programs.**

Name: _____
Gender: _____
Date of Birth: _____
Do you have any allergies: Yes____ No ____
If yes, please list: _____
_____
Emergency Contact Information:
Name:_____
Relation:_____
Phone: _____

Name: _____
Gender: _____
Date of Birth: _____
Do you have any allergies: Yes_____ No_____
If yes, please list:_____
_____
Emergency Contact Information:
Name: _____
Relation: _____
Phone: _____

If there are any additional household members, please list each person and information as listed above and attach to the application.

Please list which, if any, of these dependents residing with you are in foster care:

_____

Please list any need-based assistance you receive from either the federal or state government (for example, free and reduced lunch program, federal food stamps, Supplemental Social Security Income (S.S.I.) or S.S.D., W.I.C. Recipients, Section 8 or Public Housing, Medicaid Recipients, or Child Health Plan Plus (CHP+) :

_____
_____
_____
_____

PLEASE PROVIDE DOCUMENTATION OF YOUR CURRENT RECEIPT OF THE GOVERNMENT ASSISTANCE IDENTIFIED ABOVE OR PROVIDE CONTACT INFORMATION BELOW FOR THE AGENCY REPRESENTATIVE(S) WHO CAN VERIFY YOUR PARTICIPATION IN THE ASSISTANCE PROGRAMS.

APPLICATIONS SUBMITTED WITHOUT THIS INFORMATION WILL NOT BE CONSIDERED.

Name: _____
Agency: _____
Number: _____
Email Address (if known): _____

Name: _____
Agency: _____ Phone
Phone Number _____
Email Address (if known):_____

Name: _____ Name: _____

Agency: _____ Agency: _____ Phone Number: _____ Phone Number _____

Email Address (if known): _____ Email Address (if known):_____

I certify that all the above information is true and correct. I understand that District personnel may verify the information on the application and that a deliberate misrepresentation of the information will result in forfeiture of assistance and may prohibit future eligibility for the reduced rate program.

Signature_____Date_____

Internal Use Only:

Date Approved: _____ Approved By: _____