PETERSEN FAMILY WELLNESS CENTER
SHELBY COUNTY CHRIS A. MYRTUE MEMORIAL HOSPITAL

**Internal Use Only**
**Application #__________**

## *FIT FOR THE FUTURE*

### APPLICATION FOR FINANCIAL/SCHOLARSHIP ASSISTANCE

Date:________________________________ Membership #________________

Name:________________________________ Email Address:________________

Home Address:____________________________________________

City/State:________________________________ Zip:________________

Home Phone:________________________________ Work Phone:________________

Place of Employment (if employed):________________________________

How long have you been employed at the above?________________________________

| Spouse/Child(ren's) Name(s) | Age | Date of Birth | School/Employer |
|---|---|---|---|
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Why are you applying for scholarship assistance?________________________________

____________________________________________________________

What benefits do you see in having this scholarship to join the Wellness Center?________________

____________________________________________________________

____________________________________________________________

**Please note if you are selected to receive financial/scholarship assistance, you will be required to utilize the wellness center a minimum of 2 times per week or you may lose your eligibility for financial assistance.**

Is there anything that could keep you and/or members of your family from using the wellness center, for example:

- ☐ no transportation
- ☐ no one 18 years of age or older to accompany members of your family who are under 12 years of age, etc.
- ☐ other (please explain)____________________________________________

____________________________________________________________

**Financial Status:**

How many in your household? ________

Have you ever applied for financial assistance here before? ___Yes ___No If yes, when?________________

Your household's present annual income level is:

| | | | |
|---|---|---|---|
| ___ Under $8,000 | ___ $12,001 - $15,000 | ___ $18,001 - $20,000 | ___ Over $25,000 |
| ___ $8,001 to $12,000 | ___ $15,001 - $18,000 | ___ $20,001 - $25,000 | |

Please itemize your monthly income and expense items:

| **INCOME** | | **EXPENSES** | |
|---|---|---|---|
| Wage, salaries, and tips | $________ | Rent/Mortgage | $________ |
| Unemployment compensation | $________ | Utilities | $________ |
| Social Security compensation | $________ | Food | $________ |
| Child Support | $________ | Clothing | $________ |
| Aid to Dependent Children | $________ | Phone | $________ |
| Food Stamps | $________ | Car/Insurance | $________ |
| 401K/Retirement Funds | $________ | Alimony | $________ |
| Alimony | $________ | Child Support | $________ |
| Other | $________ | Medical | $________ |
| Assets – Home/Property/Land | $________ | | |
| Vehicles | $________ | Other | $________ |
| Cash on Hand | $________ | | $________ |
| **Total Income** | $________ | **Total Expenses** | $________ |

**Term of Agreement:** The initial term of this agreement shall be for a period of 12 months unless cancelled for breach of this Agreement. To determine continued eligibility, this Agreement will be reviewed on an annual basis. There is no guarantee this Agreement will continue unless eligibility continues to be established as stated in this Agreement.

**Payment:** In consideration for the privileges granted in this Agreement, member agrees to pay Petersen Family Wellness Center the following per month: ________________

**Failure to use Petersen Family Wellness Center shall not relieve Member of the obligation to make the payments as determined, nor entitle Member to a refund of all or any part of a payment.**

Method of payment will be: ________________________________________

________________________________________________________________

**Release of Liability:**

I. In consideration of gaining membership or being allowed to participate in the activities and programs of the Petersen Family Wellness Center and to use its facilities, equipment, and machinery in addition to the payment of any fee or charge, I do hereby waive, release and forever discharge Shelby County Chris A. Myrtue Memorial Hospital, Shelby County Medical Associates, their Board of Director and Trustees, Petersen Family Wellness Center and it's officers, agents, employees, representatives, executors, and all others from any and all responsibilities or liability for injuries or damages resulting from my participation in any activities or my use of equipment or machinery in the above mentioned facilities or arising out of my participation in any activities at said facility. I do also hereby release all of those mentioned and any others acting upon their behalf from any responsibility or liability for any injury or damage to myself, including those caused by the negligent act or omission of any of those mentioned or others acting on their behalf or in any way arising out of or connected with my participation in any activities of Petersen Family Wellness Center or the use of any equipment at Petersen Family Wellness Center. **(Please initial__________)**

II. I understand and am aware that strength, flexibility, and aerobic exercise, including the use of equipment, is a potentially hazardous activity. I also understand that fitness activities involve a risk of injury and even death and that I am voluntarily participating in these activities and using equipment and machinery with knowledge of the dangers involved. I hereby agree to expressly assume and accept any and all risks of injury or death. **(Please initial__________)**

III. I do hereby further declare myself to be physically sound and suffering from no condition, impairment, disease, infirmity, or other illness that would prevent my participation in any of the activities and programs of Petersen Family Wellness Center or use the equipment or machinery except as hereinafter stated. I do hereby acknowledge that I have been informed of the need for a physician's approval for my participation in an exercise/ fitness activity or in the use of exercise equipment and machinery. I also acknowledge that it has been recommended that I have a yearly or more frequent physical examination and consultation with my physician as to physical activity, exercise, and use of exercise and training equipment so that I might have recommendations concerning these fitness activities and equipment use. I acknowledge that I have either had a physical examination and have been given a physician's permission to participate, or that I have decided to participate in activity and/ or use of equipment and machinery without the approval of my physician and do hereby assume all responsibility for my participation and activities, and utilization of equipment and machinery in my activities. **(Please initial__________)**

By signing below, I certify that the answers and information provided in this application are true, accurate, and complete to the best of my knowledge. I acknowledge that if any answer or information is not true, accurate or complete, I may not be eligible for this program. I authorize Petersen Family Wellness Center to investigate all statements contained in this application and to contact others regarding the information I provided above. I further release from liability the Petersen Family Wellness Center and any person or organization providing information to Petersen Family Wellness Center regarding the information provided above.

**I further understand that I will be required to utilize the wellness center a minimum of 2 times per week or I may lose my eligibility for financial assistance.**

**Applicant's Signature:**______________________________ **Date:**______________________

Personal References:

Please list at least ONE or more persons as a personal reference (such as your minister, a teacher, your case worker, your employer).

| Name | Address | Phone |
| --- | --- | --- |
| | | |
| | | |
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You must attach a copy of last year's Internal Revenue Service Tax Statement and/or your SSI allocation statement to verify your annual earnings

Please attach a photo of each person included in this application.

Please complete the attached Health History Questionnaire and attach it to your application.

Please allow a minimum of two weeks before this application can be processed and approved (or denied). You will be contacted in writing from the Petersen Family Wellness Center as to the status of this application.

**If you have any questions regarding the completion of this application, please feel free to contact Todd Alberti, Executive Director at 755-4505. Thank you.**

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Application reviewed on ______________________(Date) By:____________________

___ Approved - Amount $______________________________Notified ____________

___ Denied - Reason:_________________________________Notified ____________

______________________________________________________________________