SCHOLARSHIP PROGRAM

MISSION

The mission of the TriHealth Fitness & Health Pavilion is to improve the health and wellness of the community through our facility and programs. One way we fulfill this mission is by assisting individuals who have a medical need or lifestyle behavior need for our services and who cannot afford to pay for a full membership. These scholarships are furnished to people who can demonstrate their need and reasoning for a full membership. It is also our belief that the most committed members are volunteers. You may be asked to volunteer as part of your financial assistance.

POLICY STATEMENT

It is the policy of the TriHealth Fitness & Health Pavilion to provide facilities, programs and services for individuals with medical fitness needs who desire to participate regardless of ability to pay the standard fees. Those not able to pay full fees may be awarded partial assistance based on their demonstrated ability to pay and the TriHealth Fitness & Health Pavilion's ability to fund the subsidy.

Specific dollar amounts are allocated each year to different programs and services and financial assistance will be granted within such allocations.

ELIGIBILITY

1. Assistance will be granted on the basis of medical needs and the financial needs for our programs/ services / facilities.
2. We believe a strong sense of ownership and pride is developed if the scholarship assistance recipient has contributed to the cost of their Pavilion membership, therefore, applicants may be asked to pay a minimal portion of membership dues/program fees and may be asked to volunteer at the Pavilion.
3. Financial assistance will be reviewed for eligibility every six months.
4. TriHealth Fitness & Health Pavilion has an approved scale that is used to determine your eligibility.
5. If the applicant is a minor, financial information from the parent or legal guardian will be required.

APPLICATION PROCESS

Financial assistance eligibility is determined based on a thorough review of applications.

1. Complete a health history form and physician consent form. These forms are enclosed for you and your physician to complete and return.

2. Complete the application and provide documentation of income. The following documentation is required to be submitted with your application.
    - Documentation of income (pay stubs, income tax return, forms approving or denying unemployment, disability or pension benefits)

3. Please note that when you miss a payment you will be canceled from our membership / program and you will need to reapply. If this happens three times you will not be eligible for financial assistance for one year.

4 The approval process will take 5-7 business days. We will contact you at the telephone number you provide on the application.

FINANCIAL ASSISTANCE PROGRAM APPLICATION

Name ________________________________ Home Phone (____)__________________

Home Address ____Apt. #____________________

City ____________________________________State ______________Zip Code _________

Employer _______________________________ Employer Phone _______________________

Do you have health insurance? _____ Are you active on Disability Assistance? _____

If you answered yes above, please attach a copy of your insurance card(s) to the application.

In order to process your application you must provide total income verification for 12 months prior to the date of participation for the following types of earned or unearned income:

Wages, Bonuses, Tips	Farm or Self Employment	Pensions	Public Assistance
Social Security	Workers Compensation	Strike Benefits	Unemployment Compensation
Alimony, Child Support	Military Allotments	Tax Returns	Interest, Dividends, Rents

Please provide to the hospital: (most recent pay stubs, most recent income tax return, forms approving or denying unemployment, disability or pension benefits) within 15 days of receipt of this application.

Please give the following information for yourself, spouse and all children under the age of 18 living in your home:

NAME	DATE OF BIRTH	RELATION TO YOU	SOCIAL SECURITY #	SOURCE OF INCOME	12 MONTHS PRIOR TO DATE OF PARTICIPATION

Total Household Income: _________________________

Do you have a medical need for the membership? Yes _____ No _____

(If yes, please describe and attach physician note describing medical need.)

Please tell us what you can afford to pay monthly for your membership: ____________________

(Please understand that we have a strict guideline that we use to qualify you for a monthly amount.)

List any special circumstances that contribute to your request for financial or medical assistance:

____

____

In what areas of the club would you be interested in volunteering? _________________________

How many hours / weeks could you volunteer? ____________

I certify that the Financial Assistance Application information is complete and correct. I also acknowledge that I may be asked to volunteer and my willingness to do so may affect the status of my scholarship.

Signature ____________________________ Date ______________________

TriHealth Processing Form for Financial Assistance

For Office Use Only

Name: ____________________________ Home Phone________________________

Date Received______________________ Date Contacted ____________________

Area(s) to Volunteer ______________________

Percentage of Assistance__________________

I. MEMBERSHIP PAYMENT PLAN

Amount of Membership: ____________________ Assistance Amount: ____________________

Balance: _________________________________ Monthly Payment:______________________

Date Membership Begins:____________________Date Membership Ends:_________________

II. PROGRAM PAYMENT PLAN

Amount of Program: ____________________ Assistance Amount: ____________________

Balance: _________________________________ Monthly Payment:______________________

Date Program Begins:______________________ Date Program Ends: ______________________

Payment or EFT made by checking / savings or major credit card (check one)

_____ Checking (attach voided check)
_____ Savings (attach deposit slip)
_____ Credit Card (type__________ # _______________________ expires _________

Comments:

I understand and agree to the payment contract above. All fees must be paid by the due date to fulfill the financial obligation to the TriHealth Fitness & Health Pavilion. A letter outlining these obligations will be sent to the responsible party within one week.

SIGNATURE ___________________________________ Date _________________________

Billing Signature ___________________________________ Date _________________________

Data Entry Signature ___________________________________ Date _________________________

GM SIGNATURE ___________________________________ Date _________________________