Wishing You Wellness
Subsidy Application Form

Main family contact to complete the following information. ***Please print.***

Personal Information

First Name:	Last Name:
Address:	City: Postal Code:
Phone Home: Work: Cell:	
Email:	Date of Birth: Day Month Year

Gender:
- ❑ Female
- ❑ Male

Marital Status: ❑ Single ❑ Married ❑ Common Law ❑ Separated or Divorced ❑ Widowed

How many people are in your household?_________adult(s) _______children

Please do not include roommates or other non-immediate family members (including grandparents).

Have you applied for this subsidy program in the past? ❑ Yes ❑ No
If yes, when?__________________mm/yy
Was your application approved for subsidy at that time? ❑ Yes ❑ No

Family Information

The subsidy program is for immediate family members only. Please do not add roommates, or other non-immediate family members such as grandparents. If you are approved, your TLC services are non-transferrable and non-refundable.

			Office Use Only – leave this section blank. Agency staff to complete P for Pre-Paid or M for Monthly Continuous, and Initial for Client approval.				
First and Last Name	**DOB: d/m/y**	**Age**					
Main applicant:			Product Applied for:	Client $:	WHCF $	P/M	Initial
Applicant 2			Product Applied for:	Client $:	WHCF $		
Applicant 3			Product Applied for:	Client $:	WHCF $		
Applicant 4			Product Applied for:	Client $:	WHCF $		
Applicant 5			Product Applied for:	Client $:	WHCF $		

Office Use Only:

Agency Information: Date application received: _________________Application approved:_______Yes______NO
Name of staff person:______________________________________Agency Name: ____________________________________
Signature of staff person:______________________________ Date approval sent to Foundation: _______________________

Foundation Information: Date received:________________________Date approved: _________________________________
Pass to be activated by:_________________________ Foundation Signature: ____

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Income and Assistance Verification

Please state your total net household income per month for **all adults** included on this application. $_______________

Please refer to the household maximum income chart to determine if you are eligible for the program.

Income verification is for yourself and immediate adult family members. Children **18 years of age and over,** grandparents or other extended family members must complete their own application.

This subsidy program requires that you contribute 25% of the approved amount. Are you able to meet this requirement?
________Yes ________No

Please check the box that applies to you and describe the proof of documentation you have provided.

Name of Assistance	❒ Check	List proof of documentation provided	Office Use Only – leave this section blank. Agency staff Initial approval
AISH			
Income Support			
Health Benefits			
Guaranteed Income Support			
Refugee Status			
Other			

Residency Verification

The subsidy program is only available to qualifying residents of Parkland County, The City of Spruce Grove and the Town of Stony Plain. Please provide verification of one of the following documents with the applicant's name and current address:

Name of Assistance	❒ Check	List proof of documentation provided	Office Use Only – leave this section blank. Agency staff Initial approval
Notice of Assessment			
Current Bank Statement			
Municipal Tax Notice			
Recent Utility Bill			
Other			

Application Checklist

- ❑ I have completed all the sections of this form on both sides of the page.
- ❑ I have indicated all family members who want to receive subsidy through the 'Wishing You Wellness' subsidy program.
- ❑ I have provided the required income verification documents for myself and my partner/spouse (if applicable).
- ❑ I have provided the necessary documents to provide proof of the assistance I am presently receiving.
- ❑ I have provided proof of one of the required residency verification documents.

Declaration

I hereby certify that the information in this application is true, correct, and complete in every respect. I have fully disclosed my family's income from all sources, where necessary. I understand that this application is valid for a maximum of six months and future subsidy requests will require a new application. I grant permission for_________________________________(name of referral agency) to verify any information on this application. By signing this application, I authorize my personal information to be shared with the Westview Health Centre Foundation (WHCF) for the said purposes of this program.

Signature: ____ Date: __________________________________

All Wishing You Wellness applications will be held in the strictest confidence - please allow 2 to 3 weeks for processing. Once your application has been reviewed by the referral agency, you will be contacted to advise if you have been approved, or are ineligible for the program. If approved, you will receive an email from the Westview Health Centre Foundation with the next steps to activate your pass or membership at the TransAlta Tri Leisure Centre (TLC).

All forms are to be submitted through an agency partner (Stony Plain Community & Social Development, Spruce Grove Community & Social Development, Alberta Parenting for the Future or Westview Primary Care Network).
The agency partner will process the application and forward it to the Westview Health Centre Foundation for final approval.