Licking Memorial Health Systems

Youth League Scholarship Application



Youth League Scholarship Information

Licking Memorial Health Systems (LMHS) provides registration fee scholarships to children who, without this financial assistance, might not be able to participate in one of Licking County's youth recreational athletic leagues. The LMHS Youth League Scholarship program provides opportunities for area youth to participate in recreational team sports as part of our mission to improve the health of the community. Participation in recreational team sports provides physical, mental, and character-building benefits.

If you have any questions or need assistance completing the LMHS Youth League Scholarship application, please call the Development Office at (220) 564-4102, Monday through Friday, from 8:00 a.m. to 4:30 p.m.

Eligibility

To be eligible for the LMHS Youth League Scholarship program:

- Athlete must be a Licking County resident.
- Athlete must be age 15 or younger.
- Household income must not exceed 250 percent of the federal poverty income guidelines.
- Athlete participates in a minimum of 80 percent of the scheduled practices and games.
- Participation by a family member in at least one (1) volunteer opportunity during the scholarship season.
- Athlete or parent must have completed the youth league's registration form.
- Application must be completed by a parent, guardian, or head of household, with all requested information provided.

Please provide the **total gross income** for the 3 months and 12 months immediately preceding the date for which assistance is required. This must include income for everyone living in the home. Write the total gross income in the space provided on the application on the next page. Self-employed applicants must provide gross income, less reasonable business expenses. Personal expenses are not permitted.

Proof of income is required. Examples of acceptable income verification include:

- Check stubs for the 3 and 12 months
- Documentation of Social Security, unemployment compensation, alimony, child support, or pensions

If the household earned $0 income, please complete the voucher on page 4 of this application.

Please note that school sports and travel teams are not eligible for this scholarship.

Please return the completed application to:

Licking Memorial Hospital
Development Department
1320 West Main Street
Newark, Ohio 43055



Youth League Scholarship Application

All information on this form must be completed. An individual application is required for each child.

Athlete's name: _____ Age: _____ Male/Female: _____ Birthdate: _____

Address: _____
Street City State Zip

School athlete attends: _____ Grade: _____

Athlete lives with: ( ) Both parents ( ) Mother ( ) Father ( ) Other _____

Amount of scholarship requested: Full $_____ Partial $_____

Season for scholarship request: ( ) Spring ( ) Fall ( ) Winter Year: _____

League to which this scholarship request applies: _____

Sport to which this scholarship request applies: _____

Has this athlete ever received scholarships from another resource? If yes, please list resource and year.

_____

Parent / Guardian Information

Father's name: _____ Occupation: _____

Home phone: _____ Work phone: _____ Email: _____

Mother's name: _____ Occupation: _____

Home phone: _____ Work phone: _____ Email: _____

Guardian's name: _____ Occupation: _____

Home phone: _____ Work phone: _____ Email: _____

Please provide the following information for all of the members of the household – include everyone living in the home. Provide **gross family income** for the past 3 months and the past 12 months. Include income from employment, Social Security (SS), Supplemental Security Income (SSI), unemployment compensation, alimony, child support, and pensions.

Name	Birthdate	Relationship to athlete	Gross income for past 3 months	Gross income for past 12 months
			$	$
			$	$
			$	$
			$	$
			$	$
Total persons in household:		Total family income:	$	$

By my signature below, I certify that everything I have stated on this application and on any attachments is true.

_____

Signature of applicant Date

Voucher of Unemployment and/or Zero Income for Financial Assistance Application

(Please complete this voucher only if you have no income.)

I, _____ , have not been employed, and I have received no income from

_____/_____/_____ to _____/_____/_____.
(mm / dd / yy) (mm / dd / yy)

I did not collect unemployment compensation during this period.

The following is an explanation of how I pay for my living expenses including rent, utilities, food, etc. (Do not list your bills.) *This information is required.*

_____

_____

_____

_____

_____

Consent to Release Information

(Required)

I understand that my signature authorizes LMHS to obtain verification of all information on this application and that additional information may be necessary for approval. I certify that all of the information on this form is true and correct. I understand that my child/children's participation in this program requires a commitment to attend a minimum of 80 percent of the scheduled practices and games.

_____

Parent/guardian signature Date

Licking Memorial Health Systems