



**The Maple Center, Inc. Scholarship Application
Program: LEAF/ Cancer/ Diabetes**



A Family Information:

Name _____ Birth Date ____/____/____

Address: _____ Zip Code _____

Phone # (_____) _____ - _____

Dependents by Name and Age _____

Spouse's Name _____

B Employment Information:

Employer: _____
(Circle one) **Annual** **Monthly** **Income** _____

Spouse Employer: _____
(Circle one) **Annual** **Monthly** **Income** _____

C Other Income: (Examples include Social security, annuity, pension, unemployment, etc.)

Annual _____

Monthly _____

Total Income: _____

I have applied for assistance through the following programs and was found to be eligible:

Welfare: ____ Medicaid: ____ Trustees: ____ Disability: ____ Other: _____ None: _____

Please state any other reasons you are requesting sliding fee assistance:

Verification and authorization for release of information. The above is true and correct to the best of my knowledge. I understand that I may be asked to provide proof of the information which I have given on this form, and I agree to provide The Maple Center with the necessary verifications.

Applicant signature: _____ **Spouse signature:** _____

NONPROFIT OFFICE	
Date Received _____	Staff _____
Action _____	Staff _____
Applicant Response _____	Staff _____