



Stronger Together

The Corpus Christi Community Center Application

1st Adult Last Name _____ First Name _____ Birth Date(mm/dd/yyyy) _____
Address _____ City _____ State _____ Zip _____
Primary Phone _____ Emergency Phone _____ Email _____

2nd Adult Last Name _____ First Name _____ Birth Date(mm/dd/yyyy) _____
Address _____ City _____ State _____ Zip _____
Primary Phone _____ Emergency Phone _____ Email _____

Employment Information

1st Adult Employer _____ Work Phone _____ Part Time or Full Time _____
2nd Adult Employer _____ Work Phone _____ Part Time or Full Time _____

Tax Information

All applicants must provide a copy of their most recent **Federal Income Tax Return** (form 1040, 1040A, etc.) for all adults in the household. W-2s are not accepted. If you do not have a copy of your return, you can obtain one by calling the IRS at (800)829-1040 or by visiting www.irs.gov.

I have included my most recently filed Federal Income Tax Return.

I am self-employed or own a business and have included my schedule C Tax form in addition to my 1040 form.

I did not file taxes. Please explain: _____

Other Please Explain: _____

Income Worksheet

No. of Immediate Family in Household _____
Annual Income (Verified by Taxes) \$ _____
Aid for Children \$ _____
SNAP \$ _____
Child Support \$ _____
Social Security \$ _____
Other \$ _____
Total Annual Income (Household) \$ _____

What benefits do you see having assistance to join the Community Center as a member or program participant?

Are there any extenuating circumstances that you would like to share (excessive medical expenses, unemployment, etc.?)

I am requesting assistance from the Community Center due to my personal circumstances, and verify that all information submitted is correct, complete and accurate. IF my situation changes, I agree to notify the Community Center within 30 days. If I submit false or inaccurate information or fail to notify the Community Center of a change within 30 days, I may be terminated from the Stronger Together Assistance program. Understand that my assistance will be effective for one calendar year, and I will be notified when it is time to reapply. If I do not reapply, my assistance will terminate and I will be charged the full membership price, unless I cancel my membership.

Applicants Signature: _____ Date: _____

OFFICE USE ONLY: _____ Member ID Number: _____
Date Received: _____ Staff Initial: _____ Approved Amount: _____ Membership%: _____ Program: _____