



## FINANCIAL ASSISTANCE FORM

Please complete all sections of this form for consideration. You must have a household income at or below 200% of the poverty level as determined by the U.S. Department of Health and Human Services (HHS). All financial assistance forms must be submitted with a training program application. You will be notified by U.S. mail or by phone regarding the status of your request.

Name:

Address:

City/State/Zip:

Home Phone:  Cell Phone:

Email:

Month & year attending program:

**Current source of income/monthly amount:**

Please provide proof of income by attaching a copy of (2) consecutive paystubs or any public assistance documents.

How do you plan to pay for this program and how would financial assistance impact your plans:

What are your business & professional goals?

Please include any other information that is not contained in any other area of this application that would further explain your need for financial assistance.

I hereby certify that the above information is true and correct to the best of my knowledge. I have attached additional proof of income for consideration. I understand all program fees are due by the 1<sup>st</sup> day of class whether or not financial assistance is granted.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_