

**TEXAS ASTHMA CAMP FOR KIDS
APPLICATION AND ELIGIBILITY CERTIFICATION
FOR FINANCIAL AID**

Name of Child Attending Camp _____

Name of Person Completing Form _____ Relationship to Camper _____

Address _____ City _____ State _____ Zip _____

Please check one:

- We can pay \$ _____ toward the cost of camp.
- We are requesting financial aid for: ___\$34(quarter)___ \$68 (half) ___ \$135 (full).
- We need financial aid for the full cost of camp.

Financial Information

Employer Name and Address _____

Employer Telephone Number _____ Monthly Salary _____

Spouse's Employer Name/Address _____

Spouse's Employer Telephone Number _____ Spouse Monthly Salary _____

Please List Other Income:

Social Security	_____	Veteran's Pensions	_____
Welfare Payments	_____	Interest Income	_____
Unemployment	_____	Alimony	_____
Worker's Compensation	_____	Pension/Annuities	_____
Child Support	_____		

Total Monthly Income:

Please list the name of each person including yourself who lives in your household, what their relationship is, his/her social security number and birth date:

Name	Relationship	Social Security #	Birth Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

By my signature, I agree that the information provided on this document represents an accurate and complete financial statement. I understand that it may be subject to verification.

Signature of Parent/Guardian _____