WestView
HEALTH CENTRE FOUNDATION

Wishing You Wellness Application

Main family contact to complete the following information. ***Please print.***

Personal Information

First Name:	Last Name:
Address:	City: Postal Code:
Phone Home: Work: Cell:	
Email:	Date of Birth: Day Month Year

Gender: ☐ Female ☐ Male

Marital Status: ☐ Single ☐ Married ☐ Common Law ☐ Separated or Divorced ☐ Widowed

How many people are in your household?_____adult(s) _____children
Please do not include roommates or other non-immediate family members (including grandparents).

Have you applied for this subsidy program in the past? ☐ Yes ☐ No
If yes, when?_____mm/yy
Was your application approved for subsidy at that time? ☐ Yes ☐ No

Family Information

The subsidy program is for immediate family members only. Please do not add roommates, or other non-immediate family members such as grandparents. If you are approved, the passes are non-transferrable or canceled for a refund.

Please list yourself and all family members/dependents included on this application:

First and Last Name	Birthdates (dd/mm/yy	Age	Gender (M/F)	Foundation Office Use Only Do not write in this section.	
Main applicant:				$ Amount Approved:	Client Contribution:
Applicant 2				$ Amount Approved:	Client Contribution:
Applicant 3				$ Amount Approved:	Client Contribution:
Applicant 4				$ Amount Approved:	Client Contribution:
Applicant 5				$ Amount Approved:	Client Contribution:

Referral Agency Use Only

Agency Information: Date application received: _____Application Approved:_____Yes_____NO

Name of staff person:_____Agency Name: _____

Signature of staff person:_____Date approval sent to Foundation: _____

Foundation Information: Date received:_____Date approved: _____

Pass to be activated by:_____Foundation Signature: _____

Income and Assistance Verification

Please state your total monthly net household income for **all adults** included in this application. $_____

Please refer to the household maximum income chart to determine if you are eligible for the program.

Income verification is for yourself and immediate adult family members. Children **19 years of age and over,** grandparents, or other extended family members must complete their own application.

This subsidy program requires that you contribute 25% of the approved amount.

Please check the box that applies to you and describe the proof of documentation you have provided.

Name of Assistance	Check	List proof of documentation provided	Office Use Only Do not write in this section (Staff: Initial and approve)
AISH			
Income Support			
Health Benefits			
Guaranteed Income Support			
Refugee Status			
Other			

Residency Verification

The subsidy program is only available to qualifying residents of Parkland County, The City of Spruce Grove, and the Town of Stony Plain. Please provide verification of one of the following documents with the applicant's name and current address:

Name of Assistance	Check	List proof of documentation provided	Office Use Only Do not write in this section (Staff: Initial and approve)
Notice of Assessment			
Current Bank Statement			
Municipal Tax Notice			
Recent Utility Bill			
Other			

Application Checklist

- I have completed all the sections of this form on both sides of the page.
- I have indicated all family members who want to receive a subsidy through the 'Wishing You Wellness' subsidy program. I have provided the required income verification documents for myself and my partner/spouse (if applicable).
- I have provided the necessary documents to provide proof of the assistance I am presently receiving. I have provided proof of one of the required residency verification documents.

Declaration

I hereby certify that the information in this application is true, correct, and complete in every respect. I have fully disclosed my family's income from all sources, where necessary. I understand that this application is valid for a maximum of six months, and future subsidy requests will require a new application. I grant permission for_____(name of referral agency) to verify any information on this application. By signing this application, I authorize my personal information to be shared with the WestView Health Centre Foundation for the said purposes of this program.

Signature: _____ **Date:** _____

Please allow 2-3 weeks for the processing of your application. If you are accepted into the program, you will be contacted by a staff person with more information on how to use the subsidy program. If you are ineligible for the program, you will also be contacted. Thank you for your application.

All forms are to be submitted in confidence to WestView Health Centre Foundation by e-mail to tammy.brent@albertahealthservices.ca