

**WINSLOW THERAPEUTIC RIDING UNLIMITED, INC.**  
**1433 STATE RTE 17A**  
**WARWICK, NY 10990**  
**(845) 986-6686 fax (845) 988-5980**

**SCHOLARSHIP APPLICATION**

DATE OF APPLICATION \_\_\_\_\_

RIDERS NAME \_\_\_\_\_ AGE \_\_\_\_\_ SEX: M / F

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

LEGAL GUARDIAN (S): \_\_\_\_\_

LEGAL GUARDIAN(S): \_\_\_\_\_

Financial assistance is granted on documented financial need and to the extent funds are available. Assistance will be awarded without regard to ethnicity, creed, religion, disability or national origin. All information will be kept confidential. In the chart below please circle the number of persons in your household; circle the applicable income limit listed under that household size. Total yearly income includes all sources of income for all members residing in the home.

Number in household	1 person	2 persons	3 persons	4 persons	5 persons	6 persons	7 persons	8 persons	Co-pay
(1) Equal to or less than	\$31,300	\$35,800	\$40,250	\$44,700	\$48,300	\$51,900	\$55,450	\$59,050	\$5
(2) Equal to or less than	\$47,600	\$54,400	\$61,200	\$68,000	\$73,450	\$78,900	\$84,350	\$89,800	Max \$20
(3) Greater than	\$47,600	\$54,400	\$61,200	\$68,000	\$73,450	\$78,900	\$84,350	\$89,800	Min \$20

\*Co-pay to be determined following review of individual circumstances.

Have you applied for other financial aid this year? \_\_\_\_\_ If yes, did you receive it? \_\_\_\_\_

From what agency or source(s)? \_\_\_\_\_

Explain the reason(s) for requesting this scholarship. Use the reverse side of this sheet if necessary.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SCHOLARSHIP APPLICATION**

**MOTHER'S INFORMATION:**

Name: \_\_\_\_\_ Social Security # \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_ Email: \_\_\_\_\_

Marital status: Married \_\_\_ Single: \_\_\_ Legally separated \_\_\_ Divorced \_\_\_

Employer: \_\_\_\_\_

Employers address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Job title: \_\_\_\_\_

Length of service \_\_\_\_\_ Gross annual salary \_\_\_\_\_

Does your employer match donations? \_\_\_ Y \_\_\_ N  
(If you are unsure, please ask your employer or call Winslow for assistance)

**FATHER'S INFORMATION:**

Name: \_\_\_\_\_ Social Security # \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Email: \_\_\_\_\_

Marital status: Married \_\_\_ Single: \_\_\_ Legally separated \_\_\_ Divorced \_\_\_

Employer: \_\_\_\_\_

Employers address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Job title: \_\_\_\_\_

Length of service \_\_\_\_\_ Gross annual salary \_\_\_\_\_

Does your employer match donations? \_\_\_ Y \_\_\_ N  
(If you are unsure, please ask your employer or call Winslow for assistance)

## SCHOLARSHIP APPLICATION

**FINANCIAL INFORMATION:**

**PLEASE FILL OUT COMPLETELY.** If amount is zero please indicate -0-. All monthly expenses must be included.

INCOME (MONTHLY)		EXPENSES (MONTHLY)	
Mother's net earnings		Rent/Mortgage	
Father's net earnings		Car payment	
Unemployment		Other Loans	
Child Support			
Alimony			
Pension/Retirement		Car Insurance	
Social Security		Heating/Gas	
Other _____		Electric	
		Telephone	
<b>TOTAL INCOME</b>		Cell phone	
		Cable	
Investments		Garbage Collection	
Savings		Credit cards(s)	
CDs		(monthly payments)	
Stocks			
Bonds			
Annuities		Medical expenses	
Other _____			
<b>TOTAL INVESTMENTS</b>		Child care	
		Other	
		Other	
		Other	
		<b>TOTAL EXPENSES</b>	

**OTHER DEPENDENTS:**

Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

**SCHOLARSHIP APPLICATION**

**CERTIFICATION:**

I certify that all information provided is true and that all income is reported. I agree to inform Winslow Therapeutic Center in writing of any changes in marital status or income in the month in which the changes occur. This information will be accompanied by a revised scholarship application.

I understand that I am required to participate in fund raising events at Winslow Therapeutic Center, and that I am required to sell Duck Derby tickets in the spring (minimum 2 books per rider).

I understand that my co-pay is due at time of service, and I agree to notify Winslow if my child cannot attend a session. 24 hour notice is required. I also understand that chronic absences will jeopardize my child's funding.

I am attaching copies of my 2 most recent pay stubs and a copy of my latest federal tax return.

**Parent (Guardian) Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

**Parent (Guardian) Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

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For office use only:

Notes: \_\_\_\_\_

Application complete: \_\_\_\_\_

Mother's pay stubs \_\_\_\_\_ Father's pay stubs: \_\_\_\_\_

Mother's tax return: \_\_\_\_\_ Father's tax return: \_\_\_\_\_