Coaching Scholarship Application Form

Scholarships are 50% off registration fees per session

Individual/ couple must complete the form below

Sign the application (below)

Requirements

1. Must be 18 years or older
2. Demonstrate economic need
3. Medicaid card, including Buckeye Community Health Plan; Molina Healthcare of Ohio, United Healthcare Community Plan, CareSource, Meet income eligibility requirements
4. First Name: _____ Last Name: _____
   Home Phone:_____ Cell # _____
   Email _____
   Address: _____
   City:_____ Zip Code:_____
   Annual Income: $_____ Total Number of Adults: _____ Total Number of Dependents: _____
   Circle One: M F Age: _____ Date of Birth: _____
   Ethnicity * American Indian/Native American, Asian, Black/African American Hispanic/Latino, White/Caucasian, Pacific Islander, Other, Prefer not to answer Sport
   Signature_____ * Date _____
   Member NAME _____

   comments
