

All information provided is confidential. Upon confirmation of income and residency, all copies of documents will be destroyed.

1. Please complete the full application.
2. Email the completed application **and supporting documents** to fcss@leduc.ca or mail to: FCSS, Leduc Civic Ctr, #1 Alexandra Park, Leduc.

Personal Information

Main Contact _____
first name last name

Marital Status: _____

Mailing Address _____
town/city postal code

Phone () _____ Email: _____

Income Verification for all adults in the home
(applicants must supply the current tax year Notice of Assessment for ALL Adults in the household.)

How many adults (18 + years old) live in your household (and are part of your family unit): _____

- Notice of Assessment from the most recent tax year for **all adult family members in household**
The only exception to Notice of Assessment is in the following situation:
- If you are a Refugee and Protection Claimant document was issued within the past year.
 - New Permanent Resident who arrived in Canada within the past year and hasn't yet filed taxes.

Residency Verification

The program is available to Canadian Citizens, Permanent Residents and/or Refugees that live in the City of Leduc or Rural Leduc County only.

Please check the appropriate box for the item you have included with your application.

- Most Current Notice of Assessment Recent bank statement or utility bill Municipal tax notice with address and/or legal land description
- Driver's License Copy of Lease Agreement

Recreation Assistance Program Selection

If your application is approved you will be required to select one of the following options for each applicant.

Option A - Facility Access (Free Annual Membership to the Leduc Recreation Centre and Outdoor Pool).

Option B - Funding (\$200 to use for the purchase of flex passes and/or registered program opportunities offered by the City of Leduc. (Including swimming, recreation, fitness, and children's programs).

For Office Use Only

Meets Eligibly Requirements: Yes or No (circle one)

Application reviewed on _____

Application has been _____
 approved declined Approved by: _____

Comments: _____

Please fill in all of the information below for each person included on your application.

Main Contact

Citizenship Status: _____

_____ first name

_____ last name

_____ date of birth mm/dd/yy

- male
- female
- non-binary

Please list any allergies or medical conditions that may affect your participation at our facility or in a program, or check the box below:

No known allergies or medical conditions.

Please select One Option:

Option A: Annual Membership

Option B: \$200 in funding

Applicant 2

Relation to main contact: _____

Citizenship Status: _____

_____ first name

_____ last name

_____ date of birth mm/dd/yy

- male
- female
- non-binary

Please list any allergies or medical conditions that may affect your participation at our facility or in a program, or check the box below:

No known allergies or medical conditions.

Please select One Option:

Option A: Annual Membership

Option B: \$200 in funding

Applicant 3

Relation to main contact: _____

Citizenship Status: _____

_____ first name

_____ last name

_____ date of birth mm/dd/yy

- male
- female
- non-binary

Please list any allergies or medical conditions that may affect your participation at our facility or in a program, or check the box below:

No known allergies or medical conditions.

Please select One Option:

Option A: Annual Membership

Option B: \$200 in funding

Applicant 4

Relation to main contact: _____

Citizenship Status: _____

_____ first name

_____ last name

_____ date of birth mm/dd/yy

- male
- female
- non-binary

Please list any allergies or medical conditions that may affect your participation at our facility or in a program, or check the box below:

No known allergies or medical conditions.

Please select One Option:

Option A: Annual Membership

Option B: \$200 in funding

Applicant 5

Relation to main contact: _____

Citizenship Status: _____

_____ first name

_____ last name

_____ date of birth mm/dd/yy

- male
- female
- non-binary

Please list any allergies or medical conditions that may affect your participation at our facility or in a program, or check the box below:

No known allergies or medical conditions.

Please select One Option:

Option A: Annual Membership

Option B: \$200 in funding

- I am aware if I do not use the approved funding within the deadline, I will forfeit the dollars.
- I confirm all the information I provided is correct to the best of my knowledge.

Applicant Signature: _____ Date: _____