

**2022 Application**

Referring Agency (if applicable)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact at Agency :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Applicant Information**

Caregiver(s) Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Caregiver(s) Home #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell # : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Town: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Postal Code: \_\_\_\_\_\_\_\_\_\_\_

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| **Does anyone indicated on this application identify with any of the following?** | | |
| Blackfoot | Cree | Refugee If yes, how long in Canada? |
| Metis | Inuit |  |
| Landed Immigrant If yes, how long in Canada? | | |

How many people in your family: Caregiver(S) \_\_\_\_\_ Children\_\_\_\_\_\_?

**Income – Line 15000 of 2021 Income Tax Assessment, or 3 months of pay stubs for each caregiver.**

Caregiver 1 Income Total $\_\_\_\_\_\_\_\_\_\_\_\_\_ Caregiver 2 Income Total $\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­\_\_\_\_\_\_\_\_\_

Total Family Income: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- |
| **Name** | **School** | **Grade** | **Gift Card Amount** |
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**Continued on Back**

**PLEASE READ BEFORE SIGNING**

**I hereby certify that the information contained on this application is true, correct and complete in every respect. I have fully disclosed my family’s income from all sources. Further, I agree to inform the Town of Strathmore of changes in the information given. I understand failure to do so could result in loss of entitlement to benefits under this program and is   
an offence under the Criminal Code of Canada. I understand that this application is valid for a maximum of twelve  
months and future subsidy requests will require a re-application. The Town of Strathmore may verify any information  
on this application.**

**The information on this form is being collected in accordance with the Municipal Government Act and will be managed  
in compliance with the Freedom of Information and Protection of Privacy Act. If you have any questions about the collection of your information, please contact the Town of Strathmore FOIP Coordinator at 403-934-3133.**

**Name (print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| --- | --- | --- |
| **FOR OFFICE USE ONLY Please check off documents received below:** | | |
| **AB Health Card for each child** 🞏 | **Total Household Income:** | |
| **2021 Notice of Assessment** 🞏 | **If no notice of assessment, 3 Months Pay Stubs for each caregiver** 🞏 | |
| **Completed by Staff Signature: Date:** | | |
| **Approved** 🞏 **Not Approved** 🞏 | | **Amount Approved for:** |
| **Approved by: Date:** | | |





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