ASSISTANCE APPLICATION

FIRST NAME:_____**LAST NAME**:_____

ADDRESS:_____

CITY:_____**STATE**:_____**ZIP:**_____

DATE OF BIRTH:_____**CELL #**:_____

EMAIL ADDRESS:_____

MARRIED Y:___N:____ **SPOUSE**:_____

NUMBER OF RESIDENTS LIVING IN HOUSEHOLD:_____

PLEASE LIST NAMES AND AGES:

_____

_____

_____

EMPLOYMENT STATUS:_____**INCOME**:_____

SPOUSE'S EMPLOYMENT STATUS:_____**INCOME**:_____

PLEASE SHARE YOUR DIAGNOSIS AND WHAT YOUR DIAGNOSIS IS:_____

_____

_____

_____

DATE OF DIAGNOSIS:_____

PLEASE LIST YOUR GREATEST NEED:_____

_____

_____

_____

HOW WERE YOU REFERRED TO MJ 4 HOPE:_____

I GIVE MJ 4 HOPE PERMISSION TO SHARE MY HEALTHCARE INFORMATION WITH THEIR BOARD IN COOARDINATION WITH POSSIBLE BENEFITS FROM MJ 4 HOPE. I UNDERSTAND THAT BY signing this form it does not guarantee financial assistance and it also releases MJ 4 Hope from any form of liability.

Signature:_____**Date**:_____

Relationship to Patient:_____

MJ 4 HOPE does not discriminate based on any information received.

1483 N. Mt. Juliet Rd, 175; Mt. Juliet, TN 37122 615-604-9150 amy@eventsm3.com

MJ 4 Hope Fax number: 615-296-9980

MJ 4 HOPE is a 501 (C) (3) of the Internal Revenue Code