



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 CRISIS / DIAGNOSIS:

DATE OF CRISIS / NEED /

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 COORDINATION 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 Person or Family in Crisis: _____

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

1483 N. Mt. Juliet Rd, 175; Mt. Juliet, TN 37122 629-255-0870 amy@eventsm3.com

MJ 4 Hope Fax number: 615-296-9980

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