Project Access Nashville Specialty Care
A Joint Program of the
Nashville Academy of Medicine,
The Metro Public Health Department and
Family and Children Services
3301 West End Avenue, Suite 100,
Nashville, Tennessee 37203
P: 615-712-6237
F: 615-712-6247

Date: _____ **Referring Clinic:** _____

Applicant Name: _____ **Applicant DOB:** _____

Applicant Address: _____ **Applicant Zip:** _____

Please Verify Hardship: ____ Loss of Job ____ Divorce/ Separation ____Student ____Death of Spouse

____ Other: _____

I have no proof of income because: _____

Check the box for any that the Applicant received in the last year: ☐Food Stamps ☐Unemployment

☐ Payment for contract/temporary work ☐ Disability/Social Security ☐ Housing Assistant

Name of the Applicant's Specialist(s) (for card renewals only): _____

Advocate Name: _____ **Advocate Phone:** _____

Relationship to Applicant: _____

Advocate Employer or Source of Income: _____ **Monthly Income:** _____

Option 1
I, _____ confirm that_____
does not live with me but is receiving assistance from me in the form of:

Cash in the amount of:_____/month Rent in the amount of: _____

Food in the amount of:_____/month Utilities in the amount of:_____

Option 2
I, _____confirm that _____
does live with me, and I provide all financial support for housing, utilities and food expenses.

STATE OF TENNESSEE **Applicant's Signature:** _____
DAVIDSON COUNTY
Signed and sworn before me this _____ day of _____, 2016.

[Notary Seal]

NOTARY PUBLIC My Commission expires_____.

STATE OF TENNESSEE **Advocate's Signature:** _____
DAVIDSON COUNTY
Signed and sworn before me this _____ day of _____, 2016.

[Notary Seal]

NOTARY PUBLIC My Commission expires_____.