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: ____

<u>Check the box for any that the Applicant received in the last year</u>: ☐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 _____________________, 2015.

[Notary Seal]

NOTARY PUBLIC My Commission expires__________________________.

STATE OF TENNESSEE **Advocate's Signature:** ___________________________________
DAVIDSON COUNTY
Signed and sworn before me this _____ day of _____________________, 2015.

[Notary Seal]

NOTARY PUBLIC My Commission expires__________________________.