



PROJECT ACCESS NASHILLE SPECIALTY CARE

3301 West End Ave, Suite 100
Nashville, TN 37203
615-712-6237 office
615-712-6247 fax

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

Advocate Name: _____ Advocate Phone: _____
Relationship to Applicant: _____
Advocate Source of 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
DAVIDSON COUNTY

Applicant's Signature: _____

Signed and sworn before me this _____ day of _____, 2018.

[Notary Seal]

NOTARY PUBLIC My Commission expires _____.

STATE OF TENNESSEE
DAVIDSON COUNTY

Advocate's Signature: _____

Signed and sworn before me this _____ day of _____, 2018.

[Notary Seal]

NOTARY PUBLIC My Commission expires _____.