PROJECT ACCESS NASHVILLE SPECIALTY CARE

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

## Advocate/Hardship Form

**Date:** _____ **Referring Clinic:** _____

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

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

**Verify Hardship**: ____ Loss of Job ____ Divorce/ Separation ____ Death of Spouse ____ Health Related

Other: _____

**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 Employer or 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** **Applicant's Signature:** _____

Signed and sworn before me this _____ day of _____, 2019.

[Notary Seal]

**NOTARY PUBLIC** My Commission expires_____.

**STATE OF TENNESSEE** **Advocate's Signature:** _____

Signed and sworn before me this _____ day of _____, 2019.

[Notary Seal]

**NOTARY PUBLIC** My Commission expires_____.