Assistance Application

Medical Explorers at Cox Health

PLEASE PRINT CLEARLY. Complete *ALL* information and collect all signatures as required. Hard to read or missing information and/or signatures *WILL* cause the application to be rejected.

Applicant's Name: _____ Phone _____

Address _____ City _____

State _____ Zip Code _____

Name and Age of other children in the home 1. _____ 2. _____

3. _____ 4. _____ 5. _____

Total yearly net family income ( ) Under $10,000 ( ) $10,000-$15,000 ( ) $16,000 - $20,000

( ) $21,000 - $25,000 ( ) $26,000 - $30,000 ( ) $31,000 - $40,000 ( )$41,000 - $45,000 Other _____

Do you qualify for the free and reduced lunch program _____Yes _____No

Guardian Signature _____

State the circumstances which require assistance

_____

_____

_____