

Heavenly Mimi

Application For Assistance

Full Name _____ Phone _____

Email _____ Date of Birth _____

Address _____ City/State/Zip _____

Monthly Income \$_____ How did you hear about us? _____

Monthly rent/mortgage payment _____ Phone bill per mo _____ Water bill per mo _____

Electric/gas bill _____ Car loans per month _____ Current medical debt _____

Monthly co-pays for office visits _____ Monthly health insurance premiums _____

of household members ____ Doctor name _____ Doctor phone# _____

Doctor address _____

What type of assistance do you require? (circle below)

Medical bills prescriptions hospital stay gas card mammogram other

What is your diagnosis? _____

I give my consent to Heavenly Mimi, if needed to contact my doctor to obtain additional information. I acknowledge that Heavenly Mimi will consider this full application to determine eligibility for assistance.

Signature of applicant

Date

** Please complete all fields, sign and email to caring@heavenlymimi.org
or mail to: 3131 McKinney Ave. #600, Dallas, TX 75204