Heavenly Mimi

Full Name: _____

Address: _____

Phone #: _____

Email: _____

Date of Birth: _____

Household Monthly Income: _____

Expenses:

Rent/Mortgage Payment _____

Phone Bill _____

Water Bill _____

Electric/Gas Bill _____

Car Payment _____

Current Medical Debit _____

Number of household Members: _____

Doctor's Name: _____

Doctor's Address: _____

Doctor's Phone Number: _____

What time of Assistance are you applying for? (Circle Below)

Heavenly Mimi Care Bag* Hotel Stay(Under $100) Mammogram

**Must reside in DFW Metroplex*

Diagnosis:

_____

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

_____ _____

Signature of Applicant **Date**

Send application:

Caring@heavenlymimi.org

or

511 East John Carpenter Freeway #500

Irving, Texas 75062