Wo/Men's Alliance for Medical Marijuana
COMPASSION PROGRAM APPLICATION

APPLICANT INFORMATION		
Name:		
Date of Birth:	Email:	Phone:
Current Address:		
City:	State:	ZIP Code:
Own Rent Homeless Hospitalized (Please circle)		Monthly Payment or Rent:
INCOME INFORMATION		
Current Employer:		How Long?
DEPENDENTS		
Name		Age
INCOME SOURCES	YOU	YOUR SPOUSE/PARTNER
MAJOR LOANS, DEBTS, OR OBLIGATIONS		
Description	Account No.	Amount
OTHER SOURCES OF INCOME		
Description		Amount Per Mth or Value
Signature of Applicant		Date
Signature of Co-Applicant, if for Joint Account		Date

Note: Use the back of this page to add any additional information you would like us to know about yourself.

WAMM Compassion Program Eligibility Form

Your Name	Date of Birth
Marital Status: Single___ Married___ Cohabiting___ Other______________________	

Spouse/Partner's Name	
Dependent 1 Name and Age	
Dependent 1 Name and Age	
Dependent 1 Name and Age	
Dependent 1 Name and Age	

Adjusted Gross Income from your last Tax Return	
Adjusted Gross Income from your Partner's last Tax Return	
Total Adjusted Gross Income	

Sources of Income	**How much do you receive?**		**How often do you receive it?**	
	You	Your Partner	You	Your Partner
Employment				
Self-Employment				
SSI/SSA				
Social Security Disability Insurance (SSDI)				
State Disability Income (SDI)				
General Assistance/Relief				
Private Disability				
Unemployment Insurance				
Retirement/Pension				
Worker's Compensation				
Investment or Interest Income				
VA Benefits				
Alimony				
Other				

Your Housing is: Rental Owned Homeless Hospitalized (circle one)	Monthly Housing Cost:

I declare that all the information above is true and accurate.

Signature: ____ Date: ______________________

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