Individuals may fill out the following form. Businesses may distribute this form to any/all of their employees for completion whom they wish to provide services to.

GENERAL

Last Name | First Name | MI

Phone Number | Email

Address Line 1

Address Line 2

City | State | Zip

BACKGROUND

Gender | Ethnicity | Date of Birth

Height | Weight

REQUESTING GUIDANCE & FINANCIAL AID FOR

- ☐ Fitness
- ☐ Nutrition
- ☐ Mental Health
- ☐ Other

EMERGENCY CONTACT

Relationship | First Name | Last Name

Phone Number | Email

INSURANCE

Policy Holder Name: Policy Holder DOB:

Insurance: Group #: Policy #:

Secondary: Group #: Policy #:

FINANCIAL HEALTH OF APPLICANT'S FINANCIAL PROVIDER (Self or Different)

Yes	No	
☐	☐	Are you financially independent? (Not supported by another individual)
☐	☐	Do you have any dependents? If yes, how many? _____
☐	☐	Are you currently receiving any government assistance?
☐	☐	Are you currently employed?
☐	☐	Are you on disability, a leave of absence, or retired?
☐	☐	Do you have dependents? If yes, how many? _____
☐	☐	Are you actively a student? If yes, please circle one:

Elementary Middle High College Graduate+

☐ ☐ Do you have reliable transportation to and from appointments? If yes, please circle:

Bicycle Automobile Taxi City Bus Other

Sign below to agree that all the information provided is accurate to the best of your knowledge.

Applicant's Signature Date

To complete this Application, please send this completed document, proof of your most recent 30 days of income via pay stubs, and your most recent Tax Return to sara.auld@healthpossibleinc.org or by fax to **1-833-241-7511**.