Compassion Program Application

Full Name: _____

MMJ #: _____

Marital Status: Single/ Married **(Circle One)**

Number of Dependents: _____ Number of Household Members: _____

Patients Who File Tax Returns:

Please attach a copy of your most recent tax return in its entirety.

- All pages must be signed, and all schedules must be included.
- Information on the tax return must match the patient information on record - Name, Address, etc.

Patients Who *Do Not* File Tax Returns:

Please fill out IRS Form 4506-T accordingly. This form can be located on the IRS website using web address https://www.irs.gov/pub/irs-pdf/f4506t.pdf. Once completed, mail the form to:

Internal Revenue Service
RAIVS Team
P.O. Box 145500
Stop 2800F
Cincinnati, OH 45250

Once received, the IRS will send you a "Verification of Non-Filing" letter. Information on the Non-Filing letter must match the patient information on record - Name, Address, etc. Please attach this letter to this Compassion Program application.

By signing this form, I agree and understand the above listed requirements. I am aware that any infraction of the Good Neighbor Agreement may result in loss of this discount. I am aware that the decision of my discount will be made using the most recent Federal Poverty Guidelines. I understand and agree that I must provide FSC with an updated copy of the documents required above on a yearly basis.

Patient Signature: _____ Date:_____