Evolutionary Medicine LLC

www.EvolutionaryMed.com ● (541)410-5135 ● Email: info@EvolutionaryMed.com

Low Income Application

Subject to approval. Payment due at time of service.

Requirements:	• Adult (18+) and a resident of Bend, Oregon • Able to prove financial need (200% of poverty level or DHS letter) • Suffering from some chronic physical ailment, diagnosed or not

Applicant Information	
Name:	DOB:
Phone:	Cell:
Address:	Bend, OR Zip:
Email:	

Income Information	
1st Employer:	Monthly Income:
2nd Employer:	Monthly Income:
Previous Year AGI:	Status: Single / Married / Separate / HoH
State Services / DHS received:	
Est Net Worth (Savings & Investments minus Debt):	

Health Information	
Area of Pain:	Onset:
Describe Pain:	
Previous Treatment:	

I attest that all the information provided here is accurate and complete. No sources of income have been omitted and I guarantee I am in both financial and physical need of this treatment. The standard policies of Evolutionary Medicine apply.

Signature:	Date: