

DESERT HARVEST COMPASSIONATE ASSISTANCE PROGRAM

You may be eligible to receive up to four 90-day supply of Desert Harvest Aloe Vera supplements free of charge, or at a reduced cost, depending on your income level.

To apply for the Desert Harvest (DH) Compassionate Assistance Program (CAP), read the following instructions. Please complete and sign the application and mail it to the address at the bottom of this page. Include the appropriate income documentation listed below. Incomplete applications will cause a delay in processing, so if you need assistance filling out this application, please contact Desert Harvest at (800) 222-3901.

Once accepted, you remain enrolled for one year. At the end of that year you may re-apply. It is your responsibility to call or go online to order your bottles every three months.

INSTRUCTIONS:

The DH CAP is a voluntary program that provides access to Desert Harvest Aloe Vera capsules for qualified patients. Qualifications are determined according to guidelines established by the DH CAP and in accordance with federal poverty-level guidelines.

The DH CAP and its authorized agents reserve the right at any time and for any reason to request additional information and to suspend, discontinue, or otherwise revise the aid or assistance provided, which may include removing products from the CAP or changing eligibility requirements.

ALL APPLICANTS MUST PROVIDE THE FOLLOWING:

1. Completed application form signed by applicant.
2. Copies of proof of income for applicant, applicant's spouse, dependent persons, or other persons in the household. You must submit copies of all of the following documents **for all members of the household**:
 - Federal Income Tax Form with supporting W2 Tax Statements (1040, 1040-A, or 1040-EZ, 1040-X, 1722, 8453, 8879, 1099-INT, IRS Telefile Worksheet)
 - Statements of interest, dividends, or other income (1099-INT, 1099, 1099-T, 1099-DIV)
 - Social Security, Pension, or Railroad Retirement Yearly Benefits Statement, if applicable (SSA-1099 or 4506-T)

If the applicant did not file a federal income tax return for the prior year, he/she must complete the enclosed IRS Form 4506-T, and check Box 7 to request verification of nonfiling. Please mail this form to the IRS immediately and send the answer from the IRS to Desert Harvest with this application. This form will be used to verify that you, in fact, did not earn enough income required to file taxes for the prior calendar year.

3. A letter or form from a licensed healthcare practitioner stating the disease(s) for which the supplements will be used.

RETURN COMPLETED APPLICATION TO:

CAP Administrator
Desert Harvest
20070 Roaming Drive
Colorado Springs, CO 80908

For answers to questions regarding our Compassionate Assistance Program, call (800) 222-3901.

DESERT HARVEST COMPASSIONATE ASSISTANCE PROGRAM APPLICATION

Please print clearly and in black or blue ink.
Be sure to complete all information.
Questions? Call (800) 222-3901
Remember to send IRS income documentation.

Check Your Eligibility

Please read the following eligibility requirements. If you meet the requirements, check the appropriate boxes below and complete the application. Remember to sign the application and include documentation of your income and expenses.

<input type="checkbox"/> I am a legal U.S. citizen.	<input type="checkbox"/> <i>For free aloe vera:</i> I have an annual household income equal to or less than \$11,000 for a single person; \$14,000 for a family of two; \$18,000 for a family of three; \$21,000 for a family of four; \$25,000 for a family of five; \$28,000 for a family of six; \$32,000 for a family of seven; \$35,000 for a family of 8, etc. <input type="checkbox"/> <i>For aloe vera at a reduced cost:</i> I have an annual household income equal to or less than \$22,000 for a single person; \$28,000 for a family of two; \$36,000 for a family of three; \$42,000 for a family of four; \$50,000 for a family of five; \$56,000 for a family of six; \$64,000 for a family of seven; \$70,000 for a family of 8, etc.
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Applicant Information

Applicant Name:			
Street Address:		Date of Birth:	
City:	State:	Zip:	Phone:
Number of household members including self:		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married	

Benefits/Coverage

Employer/private health coverage <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare Part A <input type="checkbox"/> Yes <input type="checkbox"/> No	
Employer/private drug coverage <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare Part B <input type="checkbox"/> Yes <input type="checkbox"/> No	
Medicaid <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare Part D <input type="checkbox"/> Yes <input type="checkbox"/> No	Social Security Disability (SSI) <input type="checkbox"/> Yes <input type="checkbox"/> No
VA or Military Benefits <input type="checkbox"/> Yes <input type="checkbox"/> No	State Patient Assistance Program (SPAP, SCHIP, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you applied for Medicaid or SS Disability in the past and been denied? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please attach copy of Medicaid or Social Security Disability denial letter.</i>		

Financial Information: List all sources of gross monthly income for all household members.

Salary/Wages	\$	Total monthly earnings from interest/dividends: \$ _____
Social Security	\$	
Child Support/Alimony	\$	
Disability	\$	
Pension/Retirement	\$	
Unemployment/Work Compensation	\$	
Total Gross Household Monthly Income	\$	

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**PROOF OF INCOME DOCUMENTATION FOR ALL MEMBERS OF THE HOUSEHOLD:**

Please check which proofs of income you have enclosed.

- Federal Income Tax Form with supporting W-2 tax statements (1040, 1040-A, or 1040-EZ, 1040-X, 1722, 8453, 8879, 1099-INT, IRS Telefile Worksheet)
- Statements of interest, dividends, or other income (1099-INT, 1099, 1099-T, 1099-DIV)
- Social Security, Pension, or Railroad Retirement Statements (SSA-1099, 4506-T)
- IRS Form 4506-T, Verification of Non-Filing

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I understand that this information will be used by Desert Harvest (DH) solely to determine my eligibility for participation in the Compassionate Assistance Program (CAP).

By signing below, I verify that the information in this application, including all copies of income documentation, is true, complete and accurate, and that I am authorized to sign this application. I understand that DH CAP has the right to verify my eligibility, including the right to audit any information provided. I agree that DH CAP has the right to contact me directly regarding DH CAP and this application and to request additional information. I also understand that DH CAP has the right to revise, change, or terminate the program at any time, and that I may revoke this consent and withdraw from participation in the CAP at any time by calling 1-800-222-3901. If I revoke this authorization, I will no longer be eligible for the program.

I understand that I must re-apply annually to continue to be part of the Desert Harvest Compassionate Assistance Program.

Applicant's Signature	Date