Patient Assistance Application

PHC
primary health care

If you would like to be evaluated for Primary Health Care's financial assistance program, you will need to complete this application and provide documentation regarding your family's gross annual income (total family income before taxes).

Only services provided on-site by PHC providers and staff will be covered as part of the Patient Assistance Program. Services that are not included in the Patient Assistance Program include but are not limited to:

- Services that are provided by referral by off-site providers, such as Specialists
- Medications dispensed by the PHC or other outside pharmacy
- Immunizations that require additional co-pay
- IUD's or other contraceptive devices

Members of Household

Please include all persons living in your home for whom you are financially responsible. Please attach an additional sheet of paper if needed.

Name________________ DOB________ Relationship________ Status________ Income: ☐ Yes ☐ No PID________

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Gross Income for Members of Household

DOES ANY HOUSEHOLD MEMBER LISTED ABOVE RECEIVE?

Employment Wages? ☐ Yes ☐ No	Public Assistance? ☐ Yes ☐ No	Social Security (SSI)? ☐ Yes ☐ No	Social Security Disability? ☐ Yes ☐No
Alimony? ☐ Yes ☐ No	Self-Employment Wages? ☐ Yes ☐ No	Retirement Benefits? ☐ Yes ☐ No	Worker's Compensation? ☐ Yes ☐ No
Unemployment Wages? ☐ Yes ☐ No	Other income/support? ☐ Yes ☐ No	Please specify:	

I hereby certify that the information provided is true. I understand that I will be responsible for 100% of the charges until Primary Health Care, Inc. receives this application and proof of income.

Patient or Responsible Party Signature________________ Relationship to Patient________________

Date____________