Eligibility Active Dates:		Financial Scale:
/ /	/ /	POI received: / /

Womankind

Financial Screening

Womankind strives to keep health care affordable for all patients. If you wish to apply for a further reduction in your cost, please complete both sides of this form. Womankind's goal is to make healthcare affordable. On the back of this form let us know if you need special consideration for discounted rates.

Name _____ DOB _____

Address: _____ City: _____ St: _____ Zip: _____

Phone: _____ Email: _____

Current Job Status (check one) ☐ Employed FT ☐ Employed PT ☐ Self Employed ☐ Unemployed

Place of employment _____ Job Title _____

Income $ _____ *per (check one)* ☐ Week ☐ Biweekly ☐ Month ☐ Yearly

Please list everyone living in your home with you that is related by blood or marriage:

Name	Relationship	Age	Monthly Income

1. Are you applying for financial assistance because Womankind does not currently accept your current health insurance?
   ☐ Yes ☐ No

2. Name of insurance_____

3. _____Initial_____ I understand that by applying for financial assistance, Womankind requires proof of income. Acceptable forms of proof of income are listed below:
   a. Recent Paystub
   b. Last year's W2 or 1099
   c. Recent Tax Return
   d. Bank Statement
   e. Employer Letter

Please Complete Other Side →

4. Initial _____ I understand that I have 45 days (_____ / _____ / _____) to provide Womankind with proof of income. Until proof of income is provided, I am expected to pay 75% of my visit costs. After proof of income is provided to Womankind, my costs will be recalculated according to my income.
5. Initial _____ I understand that if I do not provide proof of income by the date above, I forfeit my discount and I will be billed for the balance on my account.

☐ Our Bridging the Gap & Panacea Plan are an internally funded programs designed to help lower costs for those not covered by other external funding sources. If you have extenuating circumstances which affect your ability to pay, please check the box and our financial screener will have a private conversation with you regarding your situation.

_____

_____

_____

_____

I certify that the above information is true and correct to the best of my knowledge. I understand that if any of the information proves to be untrue, I will be responsible for full payment of any charges incurred. I am aware that payment is expected at the time of service.

X

Applicant Signature Date

Below for staff only

Income Information – To be Completed by Womankind Staff Only	
Patient Income	
Family Income (Related by blood or marriage)	
Total Household Income	

☐ Proof of Income Received & Scanned

☐ Eligibility Verified – Must be verified by _____ / _____ / _____

☐ Billing Alert Made

Eligibility Staff Signature Date