



The kind of health care you deserve

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.

Name: _____ DOB: _____

Email: _____ Phone: _____

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

Place of employment: _____ Job Title: _____

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

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

Name (First only)	Relationship	Age	Average Monthly Income

Proof of Income Required:

By applying for financial assistance, I understand that I must provide proof of income. Acceptable documents include:

- Recent Paystub
- W2 or 1099
- Tax return
- Bank statement
- Employer letter

If you have special or extenuating circumstances that make it hard to pay, check the box and we will have a manager speak with you privately.

I certify that the information provided is true and correct to the best of my knowledge. I understand that if any information is inaccurate, I will be responsible for the full cost of my care and that payment is expected at the time of service. I understand that I am responsible for the full cost of my visits until I provide proof of income. Once submitted, my costs may be adjusted based on my income. If I do not provide proof of income, I will not receive a discount and will be billed the full amount. I understand that this application and any approved discount are valid for one year or until my income changes.

 X _____
Applicant Signature Date