Patient Label

The Door – A Center of Alternatives, Inc.
Adolescent Health Center

FINANCIAL ASSISTANCE FORM

Legal Name - Last Name: _____ First Name: _____

Preferred name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

1. I am employed at: _____
2. Amount Paid: $ _____ ☐ Hourly ☐ weekly ☐ bi-weekly ☐ monthly ☐ annually
3. Number of Hours per Week: _____
4. Family Size (include yourself): _____
5. My family members who reside with me are (list names & relationships): _____

_____

1. I request to receive assistance with respect to paying for medical care for myself.
2. I request for The Door – Adolescent Health Center to assist me in receiving financial assistance available to me to cover the costs for medical care for myself.
3. I understand that this information is strictly confidential and may not be released to anyone outside of The Door – Adolescent Health Center.
4. I certify that all the information contained in this statement is true and correct.

Patient Signature: _____ Date: _____

Note: any person who knowingly misrepresents family size and/or gross family household income, will no longer be eligible for the sliding fee scale discount program.

I hereby acknowledge that the person named above was screened for financial assistance as part of the health center's Sliding Fee Scale Discount Program.

Staff Signature/Title: _____ Date: _____