

*Patient Data Label*

**FINANCIAL INFORMATION FORM**

Please complete this form if you would like to apply for a discount. Document all sources of income below so you are not overcharged. Our ability to discount your charges may depend on availability of government funding sources.

- I have health insurance (this includes local, out-of-state, international, student etc.)  
If you have insurance, are you the primary subscriber?  Yes  No  
**If you use your insurance the primary subscriber will receive an explanation of benefits and/or bill stating specific services received.**

- I have insurance, but don't want to use it.  
 I don't have insurance

**OR**

- I am 17 years of age or younger

**OR**

- I don't have insurance and I would like to find out if I am eligible for a discount. If so, please answer the following questions:

I am employed and earn \$ \_\_\_\_\_ per (circle one) hour week month year  
Average number hours worked per week \_\_\_\_\_

My spouse/partner/parents/other household members  
earn \$ \_\_\_\_\_ per (circle one) hour week month year  
Average number hours worked per week \_\_\_\_\_

I am in college or vocational school and receive the following funding: (circle all that apply)  
Grants                      Scholarships                      Fellowships                      Other \_\_\_\_\_  
In the amount of \$ \_\_\_\_\_ per \_\_\_\_\_

I have the following additional income (circle all that apply):  
Alimony      Child Support                      Unemployment                      Parental Support  
Social Security                      Tips                      Other \_\_\_\_\_  
In the amount of \$ \_\_\_\_\_ per (circle one) hour week month year

Household Size: \_\_\_\_\_ (number of people supported by the combined income above)

**OR**

- I prefer to pay at the full rate for Planned Parenthood of Hawaii services and not declare my income.

***I certify that the above information is accurate and complete.***

Signature \_\_\_\_\_ Date \_\_\_\_\_