Planned Parenthood® of Hawaii

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. Information on this form is used to determine your eligibility for discounts and is not used to determine if you are eligible for PPHI services. *Information on this form is confidential and will be not be released to a third party without your consent unless otherwise required by law.*

☐ 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 may receive an explanation of benefits and/or bill stating specific services received.

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

☐ I am 17 years of age or younger and am not working

☐ 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 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 _____