Buhay Wellness

Patient: _____

Date : _____

FINANCIAL ASSISTANCE ELIGIBILITY

Our clinic is committed to making care accessible regardless of financial circumstances. Patients who qualify based on household income and family size may be eligible for reduced fees or free services under our financial assistance program. Please complete this form.

Patient Information

- Patient Name: _____
- Date of Birth: _____
- Phone Number: _____
- Email: _____
- Address: _____

Household Information

- Number of people in household(including yourself): _____

Employment & Income Information

- Employer Name (if applicable): _____
- Monthly Gross Income (before taxes): $_____
- Other Monthly Income (spousal income, child support, benefits, etc.): $_____
- Total Monthly Household Income: $_____

Patient Acknowledgment

I certify that the information provided is true and complete to the best of my knowledge. I agree to notify the clinic if my financial situation changes. I understand that providing false information may result in termination of financial assistance and responsibility for all charges incurred.

Patient/Guardian Name: _____

Patient/Guardian Signature: _____ Date: _____

Clinic Representative: _____ Date: _____

FOR OFFICE USE ONLY

Determined FPL %: _____
Approved Discount Level: _____
Staff Initials: _____ Date: _____