Planned Parenthood of Delaware

Financial Information

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 insurance.

- If you have insurance, are you the policy holder? ❑Yes ❑No
- If you are not the policy holder, you **must** provide the following information on the policy holder. **Please be advised the policy holder will receive an explanation of benefits and/or bill stating specific services received.**

Primary Insurance	Secondary Insurance
Subscriber's Name_____	Subscriber's Name _____
Date of Birth_____	Date of Birth_____
SSN #_____	SSN # _____
Gender: ❑Male ❑Female	Gender: ❑Male ❑Female
Address _____	Address _____
City_____State_____Zip_____	City_____State_____Zip_____
Relationship to Patient_____	Relationship to Patient_____

AND

❑ Please answer the following questions and include financial information for all adults in the household. This information is confidential and may be used for statistical purposes and/or to see if you are eligible for a discount.

- I am employed and earn $_____ ❑hourly ❑weekly ❑bi-weekly ❑monthly ❑annually
  Average number of hours worked per week _____
- I am in college or vocational school and receive the following funding: (check all that apply)
  ❑Grants ❑Scholarships ❑Fellowships ❑Other (specify) _____
  In the amount of $_____ ❑weekly ❑bi-weekly ❑monthly ❑annually
- I have the following additional income: (check all that apply):
  ❑Alimony ❑Child Support ❑Unemployment ❑Parental Support ❑Social Security ❑Tips
  ❑Other (specify)_____ In the amount of $_____
  In the amount of $_____ ❑hourly ❑weekly ❑bi-weekly ❑monthly ❑annually

Household Size: _____ (total number of people (including yourself) supported by the combined income above)

OR

❑ I am 17 years of age or younger

OR

❑ I prefer to pay at the full rate for services rendered and not declare my income.

I certify that the above information is accurate and complete. I understand that if my Insurance Company does not reimburse Planned Parenthood of Delaware, I am responsible for any services rendered.

Signature_____ Date _____