

Patient Assistance Application

Need help paying for care? Start here. You do not need a clinic to apply.
If you do not know an answer, leave it blank. We can help you finish.

1. Who needs help? Name:

If you are filling this out for someone else: your name and relationship (optional)

2. Phone:

Email:

Give at least one way to reach you. Phone or email is enough.

City and state:

3. What help do you need? Check any that fit.

☐ Regular doctor visits ☐ Help paying for care ☐ Not sure

4. What makes paying for care difficult? Check any that fit.

☐ Low income ☐ Lost work or income ☐ Unexpected bills
☐ Other

Want to tell us more? Optional. Do not include medical details.

5. People living on your income:

About how much income each month? \$

You can write "not sure." No income documents are needed to start.

6. Clinic you would like to use (optional). Write "need help finding one" if needed.

I have answered honestly as best I can. You may contact me about this request.
Applying does not guarantee help. If approved, the Fund pays the clinic, not me.

Signature (type or sign):

Date: