



Confidential Financial Statement

White House Clinics offers several programs to assist patients with paying for health care services and medications. Each of these programs have specific criteria for enrollment and verification; however, all programs require this information be updated on an annual basis. We cannot provide a discount without a completed application and income verification.

Today's visit will be discounted based on the information provided below. **If you do not have documentation for today's visit, you will be considered self-pay until verification of your income is received.** Verification must be received before the next visit or within 30 days (whichever comes first). If you fail to provide the needed verification, you will be responsible for the full cost of all services provided.

White House Clinics reserves the right to withdraw discounts for failure to provide correct information. It is your responsibility to inform us immediately of any change in income and/or insurance status.

I attest that I have read the above statements and am completing this financial statement accurately to the best of my knowledge.

_____ **Applicant Signature & Date**

Application Date: _____

Name: _____

Date of Birth: _____

Address: _____

Phone Number: (____) ____ - ____

Has any other adult family member living in your household applied for assistance with the WHC?

_____ Yes _____ No

If yes, please list their name and date of birth. _____

Section 1: Household Size (list all family members residing in your household including applicant).

| Name | Date of Birth | Social Security Number |
|------|---------------|------------------------|
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Section 2: Income Verification (list all sources of income received by family members residing in your household on a separate line)

| Family Member | Income Type | Amount | Frequency | WHC Staff Only: Estimated Total | WHC Staff Only: Verified Total |
|------------------------|-------------|--------|--|------------------------------------|-----------------------------------|
| 1. | | | <input type="checkbox"/> Weekly (52) <input type="checkbox"/> Every Other Week (26) <input type="checkbox"/> Twice a Month (24) <input type="checkbox"/> Monthly (12) | | |
| 2. | | | <input type="checkbox"/> Weekly (52) <input type="checkbox"/> Every Other Week (26) <input type="checkbox"/> Twice a Month (24) <input type="checkbox"/> Monthly (12) | | |
| 3. | | | <input type="checkbox"/> Weekly (52) <input type="checkbox"/> Every Other Week (26) <input type="checkbox"/> Twice a Month (24) <input type="checkbox"/> Monthly (12) | | |
| 4. | | | <input type="checkbox"/> Weekly (52) <input type="checkbox"/> Every Other Week (26) <input type="checkbox"/> Twice a Month (24) <input type="checkbox"/> Monthly (12) | | |
| 5. | | | <input type="checkbox"/> Weekly (52) <input type="checkbox"/> Every Other Week (26) <input type="checkbox"/> Twice a Month (24) <input type="checkbox"/> Monthly (12) | | |
| 6. | | | <input type="checkbox"/> Weekly (52) <input type="checkbox"/> Every Other Week (26) <input type="checkbox"/> Twice a Month (24) <input type="checkbox"/> Monthly (12) | | |
| Household Total | | | | | |

| INTERNAL USE ONLY: | | | | | Effective Date | Expiration Date | Employee Signature |
|-----------------------------|---|----|-----|----|----------------|-----------------|--------------------|
| Estimated Sliding Fee Level | I | II | III | IV | | | |
| Verified Sliding Fee Level | I | II | III | IV | | | |