Pendleton Community Care, Inc.
Patient Assistance Application

Primary Care _____

Date: _____

340B _____

Name: _____ Review Date: _____

Address: _____ Medical and X-Ray Visit Fee: _____

_____ Mammography Visit Fee: _____

Phone: _____

Prescription Code: _____

% of FPL _____ %

Household Members	Acct #	Employer	Gross Annual Income (before taxes)
Adults			
1			
2			
3			
Dependent Children			
4			
5			
6			
7			
8			
Other Adults			
9			
10			
11			
Total			$

Primary Insurance: _____ Policy #: _____

_____ Group ID #: _____

_____

I certify the information I have provided on this application is valid, and complete to the best of my knowledge AND

I agree to PAY the assigned sliding scale fee at the <u>time of service</u>.

Signature: _____ Date: _____

Pendleton Community Care, Inc. Personnel: _____ Date: _____