

Pt.name MRN DOB	Affix Label
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Family Planning/Title X Hardship Declaration form

Client _____ requests a temporary financial hardship for today's Family planning services only.

New Income Worksheet has been reassessed.

Client is eligible for a temporary financial hardship after a good faith determination of financial need on (Date) _____ by the clinic staff (Clerk/Receptionist and Nurse Manager/billing department supervisor) due to the following reason as per the FPP Protocol Appendix B (Section III-C.1 Special Circumstances-Documented Hardship)

I have told the truth about ALL sources of my family's income. To the best of my knowledge. I have not withheld or given false information.

Client Printed Name

Client Signature

Date

I have seen this document and witnessed client's signature.

Staff Signature & Title

Date