PBRC Sponsorship Program Application

Today's date:	

Section 1. Personal Information

Patient Name:			
Date of birth :		Age:	
Parent or Guardian name:			
Address :			
Telephone number:			
Number of people in your family:			
Have you applied for Medicaid?	☐ Yes ☐ No		
If no, please explain:			

Section 2. Financial information:

Income

Monthly Income:	
Other income:	

Expenses

Monthly house payment (or rent):	
Monthly automobile payments:	
Other Expenses:	

Proof of income

Has your income changed drastically over the last year? Yes_____ or No _____
Explain: _____
_____

Are you currently receiving therapy at PBRC? ☐ Yes ☐No

What type of therapy are you receiving? ☐PT ☐ST ☐OT - How often?_____

What kind of sponsorship are you looking for?
Reduce therapy charges
I can only afford to pay: $_____

☐ per therapy session
☐ per week
☐ per month

Tell us your story/ Cuentame tu historia

_____
_____
_____
_____
_____
_____
_____
_____
_____

For internal use only

Patient Responsibility

I understand that I am responsible to pay _____% of the total remaining balance and that my payment of $_____ each visit will be deducted from my balance. (This does not include any co-pay that is required by your insurance company)

In addition, once discharged from services, I will make payments toward the remaining balance in the amount of $_____ per month to be received by the 10th of the month until the balance is paid in full.

Should I fail to make a scheduled payment, it could result in the therapy being placed on hold. My signature below represents my acceptance of this agreement and gives acknowledgement that you received a copy of this financial agreement.

Attendance

Patient attendance is very important to continue with therapy. Advanced notice must be given when cancelling a set appointment. In the event that advanced notice is not given the patient will receive a written notice. After 3 no-show warnings, the patient will be dismissed from the SP program and the therapy. Re-admittance to therapy will require another referral from the physician.

Patient/client's signature_____ Date _____

PBRC staff signature _____ Date _____