THE DIRECT PRIMARY CARE FUND

BENEFACTION CARE APPLICATION

Making healthcare affordable for all is the mission of The Direct Primary Care Fund and as such, we offer the ability for you the patient to have access to the healthcare you need at an affordable cost. We have partnered with Direct Primary Care Physicians to provide Benefaction, which is a limited time discount rate on their membership rates. To receive Benefaction from one of our partners we require that you complete this application and return it to us either through our secure portal on our website www.directprimarycarefund.org or you can email it to us at support@directprimarycarefund.org. We keep all information secure and confidential and do not share it with our partners. Completing this application does not guarantee benefaction will be granted. You will be notified within five business days of acceptance or denial of benefaction.

First Name:	
Last Name:	
Mailing Address:	
Phone Number:	
Email:	

1. Briefly, please tell us why you are requesting Benefaction.

2. What Physician would you like to see? _____.

3. How much does your household earn annually? $_____.

4. What are your estimated monthly debt payments? $_____.

5. Please provide the following supporting documents:

    a. Last Year's W2 **OR** Tax Form 1040 (no additional schedules needed)

    b. Last 3 Paystubs **OR** Last 3 Months Bank Statements

    c. A copy of your Driver's Licenses **OR** Passport

Your signature below means that you attest to the truthfulness of the information you have provided.

_____

Patient Signature Date

Patient Name: