ST. JOHN FISHER COLLEGE

Health and Wellness Center
Declaration of Financial Hardship

Name_____ Date _____

Student ID @ _____ Phone _____

My gross annual income: _____ Number of persons in my household:_____

Please check the answers that apply to your situation:

- ☐ I am receiving SSI.
- ☐ I am homeless.
- ☐ I pay my own medical bills.
- ☐ I am recognized as an independent student by the Financial Aid Office.
- ☐ I receive Food Stamps, WIC and/or TANF.

To be eligible to have your medical fee waived, you must meet all of the requirements below. I certify the following information (checkmark all items below that apply to you):

- ☐ I do not currently have health insurance coverage or any other financial medical assistance, including parental financial assistance with medical bills.
- ☐ I am not covered under the health insurance of my parent, guardian, spouse or significant other.
- ☐ I do not currently have the funds to pay for the medical services I have received or will receive from the Wellness Center.
- ☐ Paying for medical services I have received or will receive from the Wellness Center would cause immediate and severe personal financial hardship.

I also understand:

- ☐ that by submitting this form I give permission to the Health and Wellness Center to review my financial situation with the Financial Aid Office;
- ☐ that I must re-submit this form yearly;
- ☐ that filling out this form with false or misleading information will lead to a referral to the Office of Student Conduct.

Student Signature:_____ Wellness Staff:_____

Date:_____