 **FINANCIAL QUESTIONNAIRE** HOPE Client ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hope Medical Clinic only uses the information on this form to help in determining if the person listed is eligible for medical financial assistance and/or other aid programs/services. **NONE OF THIS INFORMATION IS REPORTED TO A GOVERNMENTAL AGENCY.**

|  |
| --- |
| Date Completed: Date reviewed with patient or family: Staff Initials: |
| **PATIENT INFORMATION:** |
| Legal Legal **Middle**  **LAST Name:** **FIRST Name:** **Initial:** |
| **Date of Birth:**  (month/day/year) **What is the BEST Contact Number for this person:** |
| **PO Box or Street Address:**  (Include apt/lot/building number) |
| **City: State: Zip Code: County:**  Washtenaw  Wayne  Other: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
|  **I am homeless at this time and the best way to reach me is:** |
| **Marital Status:**  Never Married  Married  Separated  Divorced  Widowed |
| Is this person a student?  YES  NO **If YES**, does this person have STUDENT insurance?  YES  NO |
| Is this person employed?  YES  NO |
| Is this person a US Citizen?  YES  NO |
| Is this person a GREEN CARD Permanent Resident?  YES  NO **If YES**, what year was the Green Card obtained: |
| Is this person a VISITOR?  YES  NO **If YES**, what type of VISA?  NO VISA - number of years in US: |
| Is this person LEGALLY SEEKING ASYLUM in the USA?  YES  NO |
| Is this person a US Veteran?  YES  NO **If YES**, has this person applied for VA Benefits:  YES  NO |
| **HEALTHCARE COVERAGE:** |
| Does this person have any kind of healthcare coverage?  YES  NO **If YES**, what type: |
| Has this person applied for public assistance in the last year?  YES  NO **If YES**, with what agency? |
| **HOUSEHOLD SIZE:** |
| **Does this person financially support the adults & children in their household?  YES  NO If YES, how many people is this?\_\_\_\_** |
| **If NO**, who pays the bills for the person listed above?  Spouse  Adult Child  Other Family  Friends  Church  Other  **STOP HERE. YOU DO NOT NEED TO FILL OUT THE FINANCIAL INFORMATION SECTION.** Turn this form in to the Clinic Front Desk. |
| **If YES,** **please mark who this person financially supports**:  Self  Spouse  Children  Other person(s)  This person financially supports how many children 17 years & younger \_\_\_\_\_\_\_ and how many children 18 years & older \_\_\_\_\_\_.  **\*\*COMPLETE THE FINANCIAL INFORMATION SECTION BELOW** and turn this form in to the Clinic Front Desk. |

|  |  |
| --- | --- |
| **\*\* FINANCIAL INFORMATION (only fill out this section IF this person financially supports themselves or a household.** | |
| **Patient’s MONTHLY INCOME:**  NO INCOME  Mark all that apply & put the total monthly income below:   Wages from employment   Social Security Benefits (SS, SSDI, SSI)   Unemployment benefits   Worker's Compensation   Pension and/or  Other Retirement investment money   Child support and/or  Alimony  **TOTAL MONTHLY INCOME: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Spouse’s MONTHLY INCOME:**  NO INCOME  Mark all that apply & put total monthly income below:   Wages from employment   Social Security Benefits (SS, SSDI, SSI)   Unemployment benefits   Worker's Compensation   Pension and/or  Other Retirement investment money   Child support and/or  Alimony  **TOTAL MONTHLY INCOME: $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Patient’s TOTAL MONEY ASSETS:**  NO MONEY ASSETS  Mark all that apply & put the total amount below:   Cash   Checking account   Savings account   Retirement account(s)  **TOTAL MONEY ASSETS: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Spouse’s TOTAL MONEY ASSETS:**  NO MONEY ASSETS  **(If SEPARATE from Patient)**  Mark all that apply & put total amount below:   Cash   Checking account   Savings account   Retirement account(s)  **TOTAL MONEY ASSETS: $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

REVISED: 10/06/2021