SC Initials: _____

FDOH SELF FINANCIAL EVALUATION FORM

PLEASE PRINT

NAME (Last, First, MI)	AGE	SEX	DATE OF BIRTH	SOCIAL SECURITY #

ADDRESS/PHONE

NUMBER	STREET	APT/LOT#	CITY	STATE
				FL

ZIP CODE	HOME PHONE	WORK PHONE	CELL PHONE
	( )	( )	( )

PLEASE CHOOSE ONE BLOCK BELOW AND INITIAL

☐ **If Head of Household agrees to be charged at FULL PAY (100%) instead of providing Household Income Information STOP HERE and sign below.**

☐ **To qualify for a possible reduced sliding fee scale rate, please complete entire form.**

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LIST ALL FAMILY MEMBERS WHO LIVE IN YOUR HOUSEHOLD

(Family means one or more people living in one dwelling place who are related by Blood, Marriage, Law or Conception).

NAME (Last, First, MI)	AGE	DOB (MM/DD/YY)	SOCIAL SECURITY #	RELATIONSHIP
(parent/guardian) 1.				
2.				
3.				
4.				
5.				

Family size: Adults_____ Under 21_____ Unborn(s)_____ Total_____

INSURANCE

(CIRCLE ONE)

1. Do you have MEDICAID? YES NO (IF YES, LIST MEDICAID #)_____
2. Do you have MEDICARE? YES NO (IF YES, LIST MEDICARE #)_____
3. Do have Private Insurance? YES NO (IF YES, COMPLETE INSURANCE SECTION BELOW)

	NAME OF COMPANY	INSURED'S NAME	GROUP NUMBER	POLICY NUMBER
PRIMARY CARRIER				
SECONDARY CARRIER				

EARNED INCOME BEFORE DEDUCTIONS (WHO IN THE HOUSEHOLD IS WORKING?)

NAME (Last, First, MI)	EMPLOYER (Name/Address/Phone)	GROSS INCOME (CIRCLE ONE) WEEK BI-WEEKY MONTH

UNEARNED INCOME (EXAMPLE SOURCE: VA, SOCIAL SECURITY, UNEMPLOYMENT COMPENSATION, CHILD SUPPORT, ETC.,)

NAME (Last, First, MI)	SOURCE	AMOUNT (Weekly/Bi-Weekly/Monthly)

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. I GIVE MY CONSENT TO THE DEPARTMENT OF HEALTH TO MAKE INQUIRY AND VERIFY THE INFORMATION. I UNDERSTAND THAT I MAY BE PROSECUTED UNDER LAW IF I HAVE DELIBERATELY SUPPLIED THE WRONG INFORMATION.

SIGNATURE: _____ DATE: _____

(CLIENT/PARENT/GUARDIAN)