



# Premier Community HealthCare Group, Inc.

## FINANCIAL – SELF ASSESSMENT

### *New Patient Visit Only*

Total Number of Person(s) in Household (List name, age and social security # below):

Name:	Age:	Social Security #
_____	_____	_____
Name:	Age:	Social Security #
_____	_____	_____
Name:	Age:	Social Security #
_____	_____	_____
Name:	Age:	Social Security #
_____	_____	_____
Name:	Age:	Social Security #
_____	_____	_____
Name:	Age:	Social Security #
_____	_____	_____
Name:	Age:	Social Security #
_____	_____	_____

#### CHECK ALL APPLICABLE SOURCES OF INCOME:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> ALIMONY       | <input type="checkbox"/> RETIREMENT      | <input type="checkbox"/> WORK                  |
| <input type="checkbox"/> CHILD SUPPORT | <input type="checkbox"/> SOCIAL SECURITY | <input type="checkbox"/> WORKERS' COMPENSATION |
| <input type="checkbox"/> DISABILITY    | <input type="checkbox"/> UNEMPLOYMENT    |  |

TOTAL INCOME OF HOUSEHOLD (Check one of the following) \$ \_\_\_\_\_

- |                                 |                                  |                                 |
|---------------------------------|----------------------------------|---------------------------------|
| <input type="checkbox"/> WEEKLY | <input type="checkbox"/> MONTHLY | <input type="checkbox"/> YEARLY |
|---------------------------------|----------------------------------|---------------------------------|

#### CHECK THOSE APPLICABLE:

- |                                      |                                   |  |
|--------------------------------------|-----------------------------------|--|
| <input type="checkbox"/> AFDC        | <input type="checkbox"/> MEDICARE | <input type="checkbox"/> OTHER INSURANCE |
| <input type="checkbox"/> FOOD STAMPS | <input type="checkbox"/> MEDICAID | <input type="checkbox"/> WIC             |

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_