2018 Value Care Health Clinic
Financial Review Form

Date: ___________________

Patient Name:____

Parent's Name(s): ____

Marital Status: Married Single Divorced Widowed

Total Number of Persons Living in the Household: ________________

Are you currently employed: YES NO Unemployed Since: ______________

Current Pay: $__________ every: Week Bi-Weekly Month Year

Spouse employed? YES NO Unemployed Since: ________________

Spouse's Current Pay: $___________ every Week Bi-Weekly Month Year

Living Situation: Homeless Own Home Rent Other:_______________

By signing below, you state that the information presented is true and accurate to the best of your knowledge. Also, you will notify Carin' Clinic if significant changes occur in your household income and/or living situation.

Patient's Signature: ____

Clinicial Use Only

Proof of Income Presented: YES NO

Sliding Scale Category: ______________ Medicaid #_____________________

Staff Initials: ___________