PATHWAY HEALTH CLINIC INCOME ASSESSMENT

Client Name _____ Client # _____

Are you employed? ___ Yes ___ No Are you a student? ___ Yes ___ No

Your employer: _____ Frequency of paychecks ____ Weekly ____ Two weeks ____ Monthly

Are you married? ___ Yes ___ No

Spouse's employer _____ Frequency of Paychecks ____ Weekly ____ Two weeks _____ Monthly

Do you have health insurance? ___ Yes ___ No Do you have a Medicare card? ___ Yes ____ No

Do you have an Illinois State Public Aid/Medicaid card? ___Yes ___ No

		FOR OFFICE USE ONLY
Your wages ___ paid every week (or) (check one) ___ paid every 2 weeks	$ _____ (before taxes are taken out)	Yearly $ _____
Spouse's wages ___paid every week (or) (check one) ___ paid every 2 weeks	$_____ (before taxes are taken out)	Yearly $ _____
Your partner's wages (if he/she is willing to help pay for these visits or contraceptive supplies)	$ _____ (___week or ___ 2 weeks)	Yearly $ _____
Parents (monthly) if they are helping...	$_____	Yearly $ _____
Social Security (monthly)	$_____	Yearly $ _____
Child support/alimonly (monthly).....	$_____	Yearly $ _____
Public Assistance (monthly).....	$_____	Yearly $ _____
Tips (monthly).....	$_____	Yearly $ _____
Unemployment (monthly).....	$_____	Yearly $ _____
Workmen's Comp (monthly).....	$_____	Yearly $ _____
** The number of people this income supports	_____	$ _____ Total yearly income

If your income is 0 (zero), how are you currently meeting expenses?

_____

_____ _____

Signature of client (confirming this information) Date

Qualifying programs to pay for service: _____

Family Planning	Medicaid	Health Dept. Voucher	Private Insurance
_____	_____	_____	_____
(level)	(number & expiration)		