

Family Monthly Budget

Account # _____

Patient

Name:

Marital Status:

Address:

Employer:

Occupation:

Total Annual Gross Income:

Spouse and/or Responsible Party

Name:

Marital Status:

Address:

Employer:

Occupation:

Total Annual Gross Income:

Total # of dependents in the household(including yourself):

	Total Owed	Mos. Pay
Housing		
Mortgage or rent		
Second mortgage or rent		
Phone		
Electricity		
Gas		
Water and sewer		
Cable		
Maintenance or repairs		
Subtotals		

	Total Owed	Mos. Pay
Loans		
Personal		
Student		
Credit card		
Credit card		
Credit card		
Other		
Subtotals		

Transportation

Vehicle 1 payment		
Vehicle 2 payment		
Bus/taxi fare		
Insurance		
Fuel		
Subtotals		

Saving Accts

Checking Account		
Retirement account		
Investment account		
College		
Other		
Subtotals		

Insurance

Home		
Health		
Car		
Life		
Subtotals		

Food

Groceries		
Dining out		
Subtotals		

I/we have examined this application and to the best of our knowledge belief it is true, correct and complete.

Patient _____

Responsible Party/Spouse _____

Applied for Medicaid ____yes ____no

Case Worker Name _____

Medicaid #: _____

Appointment Date: _____

Green Card: _____