DEPARTMENT OF HEALTH SERVICES **STATE OF WISCONSIN**
Division of Enterprise Services
F-80783A (01/09)

FAMILY FINANCIAL QUESTIONNAIRE

Modified for County Use

Completion of this form meets the provisions of DHS 1.02(6) and 1.03(8), Wisconsin Administrative Code. Failure to complete the form may result in the full cost of care being charged. Provision of social security numbers is voluntary; however, it is a unique identifier used to ensure proper identification of the individuals listed on this form. Personally identifiable information on this form will be used only for billing and collection purposes as specified in s. 51.30, Wisconsin Statutes.

CLIENT – Name	Social Security Number	Birth Date	Marital Status

Home Address – City, State and Zip Code	Home Telephone No. ( )

CLIENT'S FAMILY – List only the family members who are dependant on family income.

Relationship to Client	Name	Birth Date	Address and Telephone No. (if different than client's)
Spouse of a married client			
Mother of a minor client			
Father of a minor client			
Stepparent of a minor client			

DEPENDENTS A child is considered a dependent if one of the following is true about the child:

1. The child is under age 18
2. The child is a full time student under age 25 and parents provide at least ½ of support.
3. The child meets some other IRS standard as a dependent.

Child No. and Sex (circle)	Name	Birth Date	Address (if different than client's)
1. Male Female			
2. Male Female			
3. Male Female			
4. Male Female			
5. Male Female			

MEDICAL INSURANCE Insurance Type Client is Covered Under ☐ Hospital Insurance ☐ HMO ☐ Group Insurance	**1.** Insurance Company - Name and Address
Policy Number	If client has group insurance, provide "Employer's Name and Address"
Insurance Type Client is Covered Under ☐ Hospital Insurance ☐ HMO ☐ Group Insurance	**2.** Insurance Company - Name and Address
Policy Number	If client has group insurance, provide "Employer's Name and Address"

VETERANS ADMINISTRATION - Claim No.	Service Branch	Service No.

RAILROAD RETIREMENT NO.	**MEDICAL ASSISTANCE NO.**	Current ☐ Yes ☐ No	Date Certified

ASSETS

Item	Location or Description	Value	Amount Owed on the Asset	Monthly Payment	Lender or Mortgage Holder
Home					
Other Real Estate					
Automobile					
Checking Accounts					
Savings					
Stocks & Bonds Market Value					
Insurance Cash Value					
Retirement Funds & Annuities					
Snowmobiles Etc.					
Bonds Etc.					
Livestock					
Machinery					
Other-Specify:					

DEBTS NOT LISTED WITH ASSETS

Creditor	Amount Due	Monthly Payment	Creditor	Amount Due	Monthly Payment

INCOME

If you do not wish to complete this page, you must submit a copy of your most recent Wisconsin State Tax Return including all attached Federal Schedules.

A. INCOME FROM EMPLOYMENT. List earnings of the persons named on page 1. If a child is a full-time student, omit the child's income from employment and self-employment.

Person	Social Security No.	Employer Name, Address and Work Telephone No.	Income Per Pay Period		*Pay Period Code	Other Deductions Besides Social Security & Taxes? Specify Below.
			Gross	Net		
Client						
Spouse of Client						
Mother of Minor Client						
Father of Minor Client						
Stepparent						
Child Not in School (Name)						
Child Not in School (Name)						

*Pay Period Codes: (A) Weekly (B) Bi-Weekly (C) Twice Per Month (D) Monthly

B. INCOME FROM SELF-EMPLOYMENT – FARM OR BUSINESS

1. Show Annual Amounts.
2. To do this section, refer to your most recent tax returns and records. Pay particular attention to 1040 Schedules C & F.

Owner(s)	Net Taxable Income	Depreciation Claimed	Principle Paid on Depreciated Business or Property	Wages Paid of Family Members on This Form

C. INCOME FROM RENT, PARTNERSHIPS AND S-TYPE CORPORATIONS NOT REPORTED IN SECTION B., ABOVE.

1. Show Annual Amounts
2. To do this section, refer to your most recent tax returns and records. Pay particular attention to 1040 Schedule E.

Owner(s)	Net Taxable Income	Depreciation Claimed	Principal Paid on Depreciated Rental Property	Wages Paid to Family Members on this Form

D. OTHER INCOME RECEIVED MONTHLY BY FAMILY MEMBERS. Enter monthly income amounts received by family members. If income is irregular, show average monthly amounts over the past 12 months.

Income Type	Client	Spouse of Client	Mother	Father	Stepparent	Minor Children
Social Security						
Veteran's Pension						
Pensions						
Annuities						
Supplemental Security Income						
Interest						
Dividends						
Family Support						
Alimony						
Child Support						
Unemployment Compensation						
Worker's Compensation						
AFDC						
Other						
Other						

FAMILY EXPENSES

Item	Monthly Payment	Item	Monthly Payment
Rent		Union or Professional Dues	
Home Mortgage (Should be the same as page 2)		Employment Expense – If not reimbursed	
Real Estate Tax – Not paid with mortgage		Medical	
Heat: Gas / Oil Bills		Health Expense Not Covered by Insurance	
Electricity		Dental Expense Not Covered by Insurance	
Water / Sewer		Day Care Expenses	
Telephone		School Expense	
Homeowner's or Renter's Insurance		Court Ordered Payments	
Food and items bought at grocery store		Payer / Payment Type	Amount
Meals purchased away from home			
Clothing purchases and care costs			
Automobile: Gas and Oil			
Upkeep and Repairs			
Insurance		Total Monthly Payments Other Than Home Mortgage from Page 2	
Bus Fare		Other Expenses – Specify:	
Other transportation costs			
Life Insurance			
Health and Accident Insurance			

I understand that the statement made in this application must be and are to the best of my knowledge, true and correct. I also understand these statements may be verified.

SIGNATURE Date Signed