**St. Vincent de Paul Dental Clinic**



 Clinic Location:

 1906 North Street

 Prairie du Sac, WI 53578

 Phone (608) 644-0504 ext. 10

 stvdpdental@gmail.com

 **Application Guidelines**

**Purpose:** The purpose of the St. Vincent de Paul Dental Discount Program is to provide discounted dental services to qualified uninsured/underinsured clients.

**Definitions:**

* Household includes anyone who resides with you.
* Gross Income: Income is calculated based on Gross Income (money earned before deductions, such as taxes), Household money received through employment, SSDI, SSI, Unemployment, Child Support, Pension, Disability or Social Security.

**Procedure:**

* Due to cost of postage, applications will not be mailed. There are **NO EXCEPTIONS**. They will be available at the St. Vincent de Paul Resource Center and the Sauk & Columbia County Human Services buildings.
* Patient Registration application must be completed, signed, and returned prior to a scheduled appointment.
* All clients will be interviewed and approved by a St. Vincent Dental Clinic Representative based on Federal Poverty Level (FPL) guidelines according to income and family size.

**Verifications Required/Purpose of Verifications:**

|  |  |  |
| --- | --- | --- |
| Verification Needed  | Purpose  | Acceptable Documentation  |
| Income  | Verify Earnings  | (Two forms from this group) * Pay stubs (last 2 pay periods)
* Recent Tax filing
* Food Stamps
* Statement stating “no income”
* Letter from employer
* “13.7263.3 Earnings Verification” form
* Unemployment earnings
* SSI/SSDI income information
 |
| ID  | Verify Identity  | * Driver’s License
* School ID
* State Issued ID
* Passport
* Green Card
* SSN
 |
| Proof of Dependents  | Verify Responsibility of Children  | * Copy of Birth Certificate
* “Footprints” from hospital
* School Enrollment Form
* Taxes with Children Listed as Dependents
 |
| Partnership  | Verify Number of People in Household  | * Marriage License
* Bank Statements
* Lease/Mortgage with Both Names Listed
 |
| Proof of Residency  | Verify Residence  | * Recent Utility Bill
* Rental Lease
 |

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 **Patient Registration**

##  County \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## PATIENT INFORMATION

## First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial\_\_\_\_\_\_\_\_\_

## Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address 2 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## City, State, Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cellular \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Ext \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Sex □ Male □ Female Marital Status □ Married □ Single □ Divorced □ Separated □ Widowed

## Birth Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_ Social Security \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Drivers Lic\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## SECTION 2 SECTION 3

## Employment Status □ Full Time □ Part Time □ Retired Driver’s License # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Student Status □ Full Time □ Part Time Spouse’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Medicaid ID\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##  Emergency Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##  Badger Care ID\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of People in Household\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##

## RESPONSIBLE PARTY

## First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial\_\_\_\_\_\_\_\_\_

## Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address 2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## City, State, Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cellular \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ext \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Birth Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Drivers Lic \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## □ Responsible Party is also a Policy Holder for Patient □ Primary Insurance Policy Holder

## PRIMARY INSURANCE INFORMATION

## Name of Insured \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Insured □ Self □ Spouse □ Child □ Other

## Insured Soc Sec \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured Birth Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Address 2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address 2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## City, State, Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City, State, Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Rem Benefits \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Rem Deduction \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**

 **Patient Name** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Birth Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Dental Exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may

 have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the

 following questions.

|  |  |  |
| --- | --- | --- |
| Are you under a physician’s care now?  |  Yes  No  | If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Have you ever been hospitalized or had a major operation?  |  Yes  No  | If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Have you ever had a serious head or neck injury?  |  Yes  No  | If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Are you taking any medications, pills, or drugs?  Yes  No If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Do you take, or have you taken, Phen-Fen or Redux?  |  Yes  No  |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Have you ever taken Fosamax, Boniva, Actonel,  |   |  |
| or any other medications containing bisphosphonates?  |  Yes  No  |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Are you on a special diet?  |  Yes  No  |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you use tobacco?  |  Yes  No  |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you use controlled substances?  |  Yes  No  |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **WOMEN** ARE YOU:  Pregnant/Trying to get pregnant?  Yes  No Taking Oral Contraceptives?  Yes  No Nursing?  Yes  No  |

**ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?**

Aspirin  Penicillin  Codeine  Local Anesthetics  Acrylic  Metal  Latex  Sulfa drugs

Other If yes, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING?**  |  |  |  |  |
| AIDS/HIV Positive | Y N | Cortisone Medicine  | Y N  | Hemophilia  | Y N  | Radiation Treatments  | Y N  |
| Alzheimer’s Disease  | Y N  | Diabetes  | Y N  | Hepatitis A  | Y N  | Recent Weight Loss  | Y N  |
| Anaphylaxis  | Y N  | Drug Addiction  | Y N  | Hepatitis B or C  | Y N  | Renal Dialysis  | Y N  |
| Anemia  | Y N  | Easily Winded  | Y N  | Herpes  | Y N  | Rheumatic Fever  | Y N  |
| Angina  | Y N  | Emphysema  | Y N  | High Blood Pressure  | Y N  | Rheumatism  | Y N  |
| Arthritis/Gout  | Y N  | Epilepsy or Seizures  | Y N  | High Cholesterol  | Y N  | Scarlet Fever  | Y N  |
| Artificial Heart Valve  | Y N  | Excessive Bleeding  | Y N  | Hives or Rash  | Y N  | Shingles  | Y N  |
| Artificial Joint  | Y N  | Excessive Thirst  | Y N  | Hypoglycemia  | Y N  | Sickle Cell Disease  | Y N  |
| Asthma  | Y N  | Fainting Spells/Dizziness Y N | Irregular Heartbeat  | Y N  | Sinus Trouble  | Y N  |
| Blood Disease  | Y N  | Frequent Cough  | Y N  | Kidney Problems  | Y N  | Spina Bifida  | Y N  |
| Blood Transfusion  | Y N  | Frequent Diarrhea  | Y N  | Leukemia  | Y N  | Stomach/Intestinal Disease  | Y N  |
| Breathing Problem  | Y N  | Frequent Headaches  | Y N  | Liver Disease  | Y N  | Stroke  | Y N  |
| Bruise Easily  | Y N  | Genital Herpes  | Y N  | Low Blood Pressure  | Y N  | Swelling of Limbs  | Y N  |
| Cancer  | Y N  | Glaucoma  | Y N  | Lung Disease  | Y N  | Thyroid Disease  | Y N  |
| Chemotherapy  | Y N  | Hay Fever  | Y N  | Mitral Valve Prolapse  | Y N  | Tonsillitis  | Y N  |
| Chest Pains  | Y N  | Heart Attack/Failure  | Y N  | Osteoporosis  | Y N  | Tuberculosis  | Y N  |
| Cold Sores/Fever Blisters  | Y N  | Heart Murmur  | Y N  | Pain in Jaw Joints  | Y N  | Tumors or Growths  | Y N  |
| Congenital Heart Disorder  | Y N | Heart Pacemaker  | Y N  | Parathyroid Disease  | Y N  | Ulcer  | Y N  |
| Convulsions | Y N | Heart Trouble/Disease  | Y N | Psychiatric Care  | Y N  | Venereal Disease  | Y N  |
|  |  |  |  |  |  | Yellow Jaundice  | Y N |
| Have you ever had any serious illness not listed above? Y NIf yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you use any pre-medications? Y N  If yes, please list antibiotic used. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**ALWAYS CHECK WITH YOUR FAMILY DOCTOR BEFORE YOUR DENTAL APPOINTMENT TO SEE IF YOU NEED TO BE PRE-MEDICATED OR IF YOU NEED TO STOP TAKING ANY MEDICATIONS!**

**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Clinic Location:

 1906 North Street

 Prairie du Sac, WI 53578

 Phone (608) 644-0504 ext. 10

 stvdpdental@gmail.com

 **Financial Assistance Worksheet**

**Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| **INCOME**  | **SELF—MONTHLY**  | **SPOUSE/HOUSEHOLD—MONTHLY**  |
| Employment/Wages  |   |   |
| Unemployment  |   |   |
| Disability/SSI  |   |   |
| Food Stamps  |   |   |
| Child Support  |   |   |
| Other  |   |   |
| **TOTAL**  |   |   |

|  |  |  |
| --- | --- | --- |
| **EXPENSES**  | **SELF—MONTHLY**  | **SPOUSE/HOUSEHOLD—MONTHLY**  |
| Rent or Mortgage  |   |   |
| Lot Rent  |   |   |
| Utilities (water & light)  |   |   |
| Heat (gas or fuel oil)  |   |   |
| Phone Bill  |   |   |
| Food & Misc. Hygiene  |   |   |
| Vehicle Payment  |   |   |
| Homeowner’s/Car Insurance  |   |   |
| Gasoline  |   |   |
| Health Insurance  |   |   |
| Credit Card Payments  |   |   |
| Medication Expenses  |   |   |
| Clinic/Hospital Bills  |   |   |
| Alimony/Child Support  |   |   |
| Storage Unit  |   |   |
| Cigarettes/Alcohol  |   |   |
| Cable/Satellite/Internet/Direct TV  |   |   |
| Other Expense  |   |   |
| **TOTAL**  |   |   |