HCFS
Performance Driven. Patient Oriented.

HCFS PRIMARY QUESTIONNAIRE

HOSPITAL #: _____ **PATIENT NAME:** _____ **ACCOUNT#(S):** _____

DOS: _____ **DECEASED:** _____ **MINOR:** _____ **Pregnant:** _____ **MEDICARE:** _____ **PART(S)?** _____

DOB: _____ **Social Security #:** _____ **Disabled:** _____ **SPANISH SPEAKING:** _____

PATIENT INFORMATION: Gender: _____ Citizen: _____ F/T Student: _____ Contact Number(s): _____

Address: _____
Street City State Zip County

Treated For: _____ Other Major Health Issues: _____

Have you ever applied for state, federal or county assistance? (Food stamps/Medicaid/Disability) What/When: _____

Do you have any insurance or medical coverage? (VA/IHS/School/Commercial) **** If yes complete Existing Insurance Form***

In the last 3 months were you medically insured? _____ Date Termed: _____ Cobra Elected? _____

HOUSEHOLD INFORMATION **How many people live in the home?** _____

Name	Relationship	Age	C/R/IA	Pregnant/Disabled	Legal Custody (Does patient have legal guardianship of minor)

INCOME INFORMATION **What are the sources of income for the household?**

Person	Employer/Source & Phone #	Frequency of Payment	Monthly Gross

Do you receive any contributions from outside the household? _____ How much? _____

VEHICLES/RESOURCES

Do you own any vehicles?

Year	Make	Model	Title	Amount Owed

Life insurance with a cash value: Amount: $_____

Burial Insurance: Amount: $_____

Stocks/Bonds/401K: Amount: $_____

BANK ACCOUNTS Checking/Savings/Certificate of Deposit/IRA

Bank Name _____ Amount _____

Bank Name _____ Amount _____

RESOURCES

Do you own anything of resource or value? YES/NO
(Additional Property, Boat, Motorcycle, RV, ATV, Livestock)

What: _____ Value: $_____
What: _____ Value: $_____
What: _____ Value: $_____

Program Being Pursued: _____ **PAR Name:** _____

Close Code: _____ Date and Time Completed: _____