FAMILY AND FINANCE LLC

Entered in Hub_____

Today's Date _____

ACA Healthcare Questionnaire

Name: _____ DOB: _____ SS# _____

Spouse: _____ DOB: _____ SS# _____

Dependents: YES NO Medicaid/CHIP:

_____

_____

Address: _____

City: _____ Zip Code: _____

Phone: _____

E-mail: _____

Monthy or Weekly Income: _____

Employer: _____

Address: _____

Phone: _____

Occupation: _____

PCP: _____

Phone Number: _____

Smoker: YES NO

***Please Sign Consent:** _____

Notes:

_____

_____

_____

_____