Intake Form

Individual/ Family Health Coverage

Applicant: _____ DOB: _____ M/F: _____

Address: _____

City: _____ Zip: _____ County: _____

SSN: _____ Tobacco/Non-Tobacco: _____

Phone Number (work/home/cell): _____

Email: _____

Check for ACA subsidy: Y/N
If yes filing status: _____ Adjusted Gross Income _____ # in household ____
Employer Name and Phone Number: _____

Additional People in household (spouse/domestic partner/dependents):

- **Name, relationship, DOB, SSN and income. Use back if need be**

_____

_____

_____

_____

Current health plan_____ Current monthly premium_____

Happy with plan? Why or why not

_____

_____

Current Doctors & Meds (doc name and location – med name and strength)

_____

_____

_____