PHFA CMF Resident Questionnaire

Head of Household	Unit Number

Childcare Expenses		Amount Paid per Month
Do you pay for childcare expenses for a child (or children) under age 13 because you: Work ☐ Are actively looking for work ☐ Attend School ☐	☐ Yes ☐ No	$
If yes, enter the provider name(s) and address(es):		
Is any part of the expense paid by another person or agency?	☐ Yes ☐ No	$
If yes, enter the name(s) and address(es):		

Disability Assistance Expenses		Amount Paid per Month
Do you pay for attendant care services or any equipment for a disabled household member to enable that person, or someone else in the household to work?	☐ Yes ☐ No	$
If yes, enter the provider name(s) and address(es):		
Is any part of this expense paid by another person or agency?	☐ Yes ☐ No	$
If yes, enter the name(s) and address(es):		

	Medical Expenses *(complete only if the head, co-head, or spouse is at least 62 years old or disabled)*		Amount Paid per Month
	Do you pay for:		
1.	Medicare	☐ Yes ☐ No	$
2.	Medicare Part D	☐ Yes ☐ No	$
3.	Other medical insurance premium	☐ Yes ☐ No	$
4.	Do you pay for prescription medications?	☐ Yes ☐ No	$
5.	Do you pay for any non-prescription medication that your doctor has asked you to use regularly? (aspirin, insulin, etc.)	☐ Yes ☐ No	$
6.	Do you expect to have any medical or dental expenses in the next 12 months?	☐ Yes ☐ No	$

If yes to questions 3-6, provide the information below for all unreimbursed medical expenses for all household members (attach additional page if needed).

HH Member	Name	Types of Medical Expense and Provider Name and Address	Amount
			$
			$
			$
			$
			$
			$

I certify under penalty of perjury that the information provided is true and correct to the best of my knowledge.

Applicant/Resident Signature	Date
Applicant/Resident Signature	Date
Applicant/Resident Signature	Date