

## Certification of Low Income Status Income Assessment Worksheet

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Sources of Income:** All dependent family members living in household. Does not include guests, roommates or independent family members.

<u>Source:</u>	<u>Amount</u>	<u>Wkly</u>	<u>Bi-Wkly</u>	<u>Monthly</u>	<u>Annual</u>
Salaries & Wages (Self)	_____	[ ]	[ ]	[ ]	[ ]
Salaries & Wages (Spouse)	_____	[ ]	[ ]	[ ]	[ ]
Pension Plan/IRA/Keogh Plan	_____	[ ]	[ ]	[ ]	[ ]
Workman's Comp (SIIS)	_____	[ ]	[ ]	[ ]	[ ]
Social Security (Children)	_____	[ ]	[ ]	[ ]	[ ]
SSI (Supplemental Security)	_____	[ ]	[ ]	[ ]	[ ]
Child Support/ Alimony	_____	[ ]	[ ]	[ ]	[ ]
Tip Income (Documented)	_____	[ ]	[ ]	[ ]	[ ]
Interest Income	_____	[ ]	[ ]	[ ]	[ ]
Military / Veterans Benefits	_____	[ ]	[ ]	[ ]	[ ]
Unemployment Benefits	_____	[ ]	[ ]	[ ]	[ ]
Public Assis. / Food Stamps	_____	[ ]	[ ]	[ ]	[ ]
Other Family Members	_____	[ ]	[ ]	[ ]	[ ]

**Family Size:** List all household family members by Name, Birthdate and Social Security Number, include yourself.

<u>Name</u>	<u>Birthdate</u>	<u>Social Security #</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____