

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: _____