

Patient Income Assessment

Date _____/_____/_____

_____	_____	_____
Last name	First Name	Middle Name
_____/_____/_____	_____	_____/_____/_____
Birth Date		Social Security

*All persons living in the same household
(with you in the United States)
who are related by blood, marriage, legal
adoption and/or meet the definition of a
tax dependent.*

\$ _____
Gross Monthly Income

Family Size

Income Source:

<input type="checkbox"/> Salaries, wages, tips, commissions	<input type="checkbox"/> Social Security Benefits
<input type="checkbox"/> Public assistance	<input type="checkbox"/> Alimony and child support payments
<input type="checkbox"/> Unemployment compensation	<input type="checkbox"/> Workman's compensation
<input type="checkbox"/> Pension	<input type="checkbox"/> Business profits
<input type="checkbox"/> Veteran's Benefits	<input type="checkbox"/> Net earnings from self employment
<input type="checkbox"/> Net Investment Income (rent, interest, dividends)	
<input type="checkbox"/> Other cash income or allowances from any resources which are readily available to the family	

For LCHHS Use Only

Income documentation provided:

<input type="checkbox"/> Current payroll or check stub	<input type="checkbox"/> Other _____
<input type="checkbox"/> Award Letter	_____
<input type="checkbox"/> Court Documents	_____
<input type="checkbox"/> Tax Returns	
<input type="checkbox"/> Current Commissions Statement	

FPL: _____ % discount eligible for: _____

Verified by: _____ Input into OCHIN: _____