2017 Client Income/Expense Worksheet

ASSISTANCE REQUESTED: (PLEASE CHECK BOXES FOR ALL ASSISTANCE REQUESTED)

☐RENT/MORTGAGE ☐ELECTRIC ☐HEATING ☐MEDICAL ☐DENTAL ☐OPTICAL ☐FOOD

☐PRESCRIPTION ☐TRANSPORTATION ☐COUNSELING ☐EDUCATIONAL ☐TRAINING

OTHER:_____

ACTUAL HOUSEHOLD INCOME/BENEFITS FOR PAST 30 DAYS:

Name			Name		
	EMPLOYMENT – YOURS:	$		MONTHLY CHILD SUPPORT(Received):	$
	EMPLOYMENT – SPOUSE:	$		UNEMPLOYMENT:	$
	SOCIAL SECURITY – YOURS :	$		PENSION:	$
	SOCIAL SECURITY – SPOUSE :	$		WORKER'S COMP:	$
	SSI BENEFITS:	$		OTHER:	$
	SNAP AMOUNT:	$		OTHER:	$
	SNAP AMOUNT	$		OTHER:	$
	HOUSING ASSISTANCE:	$		OTHER:	$
	TANF:	$	**Total Monthly Income/Benefits:**		**$**

ACTUAL BILLS FOR PAST 30 DAYS:

(VOLUNTEERS PLEASE PLACE A CHECK IN THE SQUARE BY EACH BILL ACTUALLY PAID)

	RENT/MORTGAGE:	$			CELL PHONE:		$
	ELECTRIC:	$			CABLE/INTERNET:		$
	HEATING:	$			OTHER:		$
	WATER/SEWER:	$			OTHER:		$
	FOOD:	$			OTHER:		$
	MEDICAL:	$			OTHER:		$
	AUTO PAYMENT:	$			OTHER:		$
	GASOLINE:	$			OTHER:		$
	CAR INSURANCE:	$			OTHER:		$
	HOME INSURANCE:	$	**TOTAL MONTHLY EXPENSES:**				$
	LIFE INSURANCE:	$	**TOTAL INCOME:**				$
	HOME PHONE:	$	**INCOME – EXPENSES=**				+ - $

THIS SECTION FOR OFFICE USE ONLY:

DATE:_____ INTERVIEWER:_____

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