

Monthly Income and Expense Detail

Every patient must complete this form. Pharmacy staff will help you complete the bottom portion below the line.

Income from Employment

Name of Employer _____ Unemployed

Wage Amount: _____ Wage Frequency: Hourly Daily Weekly Monthly Yearly

Taxes Paid Last Year _____ Tax Refund Last Year _____ No Taxes Filed Last Year

Income from Other Sources

In order to verify your total annual income, we must account for all types of income received. Apart from wages or a from a place of employment, your "Income" includes any payments received from any of the following sources. If possible, please provide any statements or documentation which show these payments:

- Tips,
- Unemployment benefits,
- Social Security benefits,
- Welfare benefits,
- Disability, worker's compensation, or other payments for an injury or illness,
- Retirement or Pension benefits,
- Alimony or Child Support payments,
- Annuity or Life Insurance payments,
- Interest or Dividends from savings accounts or Investments, or any withdrawals from these accounts,
- Rental Income or income from your business,
- Income from Royalties, Patents, Gambling or Lottery winnings.

Expense Detail

In the table below, please list the costs of your living expenses. You do not have to list the exact amount; just estimate the average within a few dollars.

Expense	Monthly Cost	Expense	Monthly Cost
Rent/Mortgage		Food	
Utilities (Electricity, Water, etc)		Clothing, Hygiene, Basic Needs	

PHARMACY STAFF: Income from Other Sources Detail

Source/Organization	Monthly Amount Paid

Total monthly household income: _____ Total annual household income: _____

I have reviewed this income section with the applicant and verified their total annual household income.

Intake Screener Signature _____ Date _____