Income/Benefits Assessment

**** Must be collected at Entry, Exit and at least Once Annually ****

Date: _____/_____/_____ **Staff Member:** _____

Name:_____
(First) (Last)

Social Security Number:_____-_____-_____ Birth Date: _____/_____/_____

Income Group: ☐ Cash Income ☐ Non-cash Benefit

Income received from any source in past 30 days? ☐ No ☐ Yes ☐ Don't Know ☐ Refused

Non-cash benefit received in past 30 days? ☐ No ☐ Yes ☐ Don't Know ☐ Refused

√	Type	Description	Amount
	CASH INCOME		Past 30 days
	Earned Income		
	Unemployment Insurance		
	Supplemental Security Income		
	Social Security Disability Income		
	Veteran's Disability Payment		
	Private Disability Insurance		
	Worker's Compensation		
	TANF		
	General Assistance		
	Retirement (Social Security		
	Veteran's Pension		
	Other Pension		
	Child Support		
	Alimony		
	Other Income		
	No Financial Resources		
	NON-CASH BENEFITS		Past 30 days
	Food Stamps/Money for food on benefits card		
	MEDICAID		
	MEDICARE		
	State Children's Health Insurance Program (CHIPS)		
	Special Supplemental Nutrition Program for Women, Infants & Children (WIC)		
	Veteran's Administration Medical Services		
	TANF Child Care Services		
	TANF Transportation Services		
	Other TANF-funded Services		
	Section 8, Public Housing or Other Rental Assistance		
	Other Source		