

Patient Worksheet for Assistance Applications

Please provide this to your patient to complete. Do not send this form to KFO once completed, but use this to input the information into the application portal.

Presently Employed? ___Yes ___No **How many people live in the household?** _____

Monthly Household Income

Please list income from all household members below.

	<i>Salary</i>	<i>SSI/SSDI</i>	<i>Pension</i>	<i>Child Support</i>	<i>TANF (include Ohio Works First Program)</i>	<i>Food Assistance Program, SNAP</i>	<i>Unemployment Compensation/ Worker's Compensation</i>	<i>Short Term or Long term disability from employer</i>
<i>Applicant</i>	\$	\$	\$	\$	\$	\$	\$	\$
<i>Spouse</i>	\$	\$	\$	\$	\$	\$	\$	\$
<i>Child #1</i>	\$	\$	\$	\$	\$	\$	\$	\$
<i>Child #2</i>	\$	\$	\$	\$	\$	\$	\$	\$
<i>Other</i>	\$	\$	\$	\$	\$	\$	\$	\$
<i>Total</i>	\$	\$	\$	\$	\$	\$	\$	\$

Total combined monthly income from all sources listed above \$ _____

Annual income (Number listed above x 12) \$ _____

Total monthly income from all sources not listed above \$ _____

If monthly income is left bank, please specify why: _____

Monthly Expenses

Item	Monthly Payment Amount
Medication (Out of pocket cost only)	\$
Rent/Mortgage	\$
Utilities (Combined Monthly Average)	\$
Groceries	\$
Transportation (Bus Fare, Gas, Taxi, Uber/Lyft)	\$
Insurance (car, home, life)	\$
Car Payment	\$
Entertainment	\$
Telephone (Include Cell Phone)	\$
Tuition/Education (Include Student Loans)	\$
Other Loan Payments (List Type) _____	\$
Credit Card Payments (Total per month)	\$
Doctor/Hospital (Copays, Deductibles, Monthly out of pocket cost only)	\$
Medicare Premiums (Part B, Part D, Supplemental) <i>Not deducted from SSA</i>	\$
Other Medical Expenses (List Type) _____	\$
Other Expenses (List Type) _____	\$

Total monthly expenses from all sources listed above \$ _____