FINANCIAL VERIFICATION

Client Name: _____ Client Birth Date: _____
Last First Middle Month/Day/Year

Check here if same client

Name: _____ Date of Birth: _____
Last First Middle Month/Day/Year

Monthly Income (*List source of monthly income BEFORE taxes and for All household members)*

Income Source	Amount
Wages / Salary of Client	
Wages / Salary of Husband /Wife	
Wages / Salary of Partner	
Wages / Salary of Parent / Guardian	
PA - General Assistance - or AFS / AFDC	
PA - Worker's Comp. / Unemployment	
PA - Housing Assistance - Amount HUD Pays	
PA - Social Security Income	
PA - Disability Income	
Other Income Pension/Veteran/Retirement	
Other Income Alimony / Child Support	
Other Income Dividend/Interest Invest.	
Other Source - Relationship to Client	
Total Monthly Income	
Total Annual Income (x 12 months)	

How many people (in each age group) live on this income and in this home?

Age 0 – 5 _____ Age 6 – 17 _____ Age 18 – 64 _____ Age 65+ _____

I accept the above conditions and agree that information provided is true and correct to the best of my knowledge

_____ _____
Signature Date

FOR OFFICE USE ONLY DISCOUNT % _____ **INITIALS:** _____

Name _____

Benton County Health Department • 530 NW 27th Street
P.O. Box 579 • Corvallis, OR 97339 • ADF-0158df pc:09/08

Client # _____ DOB _____