DEPAUL COMMUNITY HEALTH CENTERS

HOUSEHOLD ASSESSMENT

Income Level

		1		2		3		4	
% FPL		100%		101-150%		151-200%		Over 200%	
		From	To	From	To	From	To	Above	
Household Size	1	$0	$13,590	$13,591	$20,385	$20,386	$27,180	$27,181	
	2	$0	$18,310	$18,311	$27,465	$27,466	$36,620	$36,621	
	3	$0	$23,030	$23,031	$34,545	$34,546	$46,060	$46,061	
	4	$0	$27,750	$27,751	$41,625	$41,626	$55,500	$55,501	
	5	$0	$32,470	$32,471	$48,705	$48,706	$64,940	$64,941	
	6	$0	$37,190	$37,191	$55,785	$55,786	$74,380	$74,381	
	7	$0	$41,910	$41,911	$62,865	$62,866	$83,820	$83,821	
	8	$0	$46,630	$46,631	$69,945	$69,946	$93,260	$93,261	

Please list income for all household members. This does not include guests, roommates, or non-dependent family members.

Source	Amount	Weekly	Biweekly	Monthly	Annually
Salaries and Wages (Self)	$	☐	☐	☐	☐
Salaries and Wages (Spouse)	$	☐	☐	☐	☐
Workman's Comp	$	☐	☐	☐	☐
Social Security	$	☐	☐	☐	☐
SSI (Supplemental Security)	$	☐	☐	☐	☐
Child Support/Alimony	$	☐	☐	☐	☐
Tip Income	$	☐	☐	☐	☐
Military/Veterans Benefits	$	☐	☐	☐	☐
Public Assistance/Food Stamps	$	☐	☐	☐	☐
Stocks/CDs/Savings	$	☐	☐	☐	☐
Interest Income	$	☐	☐	☐	☐

Please list all dependent family members by NAME, DATE OF BIRTH and SOCIAL SECURITY NUMBER.
Please be sure to include yourself.

Name	Date of Birth

DePaul Community Health Centers reserves the right to inspect your tax return and/or wage statement for previous periods upon request. Eligibility will be updated on an annual basis. Please notify us immediately if there are any changes in your income status prior to your annual update.

☐ I hereby certify that the income and family composition information supplied above is true and correct to the best of my knowledge. I understand that the document will be maintained in my permanent file and that falsification of any of the information above may constitute a federal offense.

☐ I refuse to complete this assessment. I understand that my refusal to take this assessment will make me ineligible for the sliding fee scale discount.

Patient Signature Date

Printed Patient Name