DAUGHTERS OF CHARITY
SERVICES OF NEW ORLEANS

HOUSEHOLD ASSESSMENT
Patient Discount Eligibility

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

Source	Amount	Weekly	Bi-Weekly	Monthly	Annually
Salaries and Wages (Self)	$_____	☐	☐	☐	☐
Salaries and Wages (Spouse)	$_____	☐	☐	☐	☐
Pension Plan / IRA	$_____	☐	☐	☐	☐
Workman's Comp	$_____	☐	☐	☐	☐
Social Security	$_____	☐	☐	☐	☐
SSI (supplemental security)	$_____	☐	☐	☐	☐
Child Support / Alimony	$_____	☐	☐	☐	☐
Tip Income	$_____	☐	☐	☐	☐
Interest Income	$_____	☐	☐	☐	☐
Military / Veterans Benefits	$_____	☐	☐	☐	☐
Public Assistance / Food Stamps	$_____	☐	☐	☐	☐
Stocks / CDs / Savings	$_____	☐	☐	☐	☐

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

NAME	BIRTH DATE	SOCIAL SECURITY NUMBER
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Daughters of Charity Health Centers reserve the right to inspect your tax return and/or wage statement for pervious periods upon request. Eligibility will be updated on an annual basis. If there are any changes in your income status prior to your annual update, you should notify us immediately.

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

_____ _____

Signature Date