

ST. AGNES ADULT DAY SERVICES CENTER PARTICIPANT'S FINANCIAL DISCLOSURE FORM

Participant's Name: _____ Age: _____

Address: _____

Primary Care Giver: _____

Address: _____ Phone: _____

Monthly Household Income (Participant, Spouse, and dependents living with Guest)

Social Security Income: _____ S.S.I.: _____

Pensions: _____ Savings (Total): _____

(Interest): _____

Social Security Disability: _____ Stocks & Bonds: _____

VA Benefits: _____ Wages: _____

Workmen's Comp: _____ Net Rental Income: _____

Railroad: _____ Black Lung Benefits: _____

Disability Insurance: _____ Other Income: _____

Deemed Income from Fixed Assets: _____

PLEASE ATTACH A COPY OF THE MOST FEDERAL INCOME TAX RETURN FOR THE PARTICIPANT AND SPOUSE. IF A TAX FORM WAS NOT FILED, WE NEED A COPY OF THE SOCIAL SECURITY BENEFIT.

To the best of my knowledge, the above information is accurate. I understand that this information will be shared with the United Way of Porter County and will be kept in strict confidence otherwise.

Signature: _____ Date: _____

(Client / Caregiver / POA)

OFFICE USE ONLY

Client Cost Share (based on above information) _____ %

United Way of Porter County Scholarship Share _____ %