

First Name	Last Name	SSN	Date of Birth
Address	Address City	State	Zip
Spouse/Other First Name	Spouse/Other Last Name	Spouse/Other SSN	Spouse Date of Birth
Phone	Email		

Employer	Spouse Employer	Other Income (rental, farm, child support, IRA, etc.)	
Gross Income	Spouse Gross Income	TOTAL INCOME	
Less Taxes	TOTAL DISPOSABLE HOUSEHOLD INCOME		
What other means have you applied for?			Accepted? YES NO
Date denied or other assistance: (send copy of denial)	Dependents: # (Total number in family; as claimed on tax filings)		
List names of all family members			
Family Dr.	Savings	Checking	Other:
Property: Rent Own	Residence Payment	Automobile Payment	Other Vehicle Payment

Groceries	Utilities	Telephone	Cable	Auto (gas/repair)
Clothing	Insurance	Child Support	Miscellaneous	

Other expenses please use back of page to list creditors, credit cards, medical bills, etc.

Return this signed copy within 10 days to Camber Children's Mental Health at 4300 Brenner Dr., Kansas City, KS 66104. Please include a copy of last year's tax return and/or a current monthly pay stub.

Signature

Date