Annual Income Review

Grant Year:________

Excluding your FGP stipend, please list all sources and monthly amounts for your income for *yourself and your spouse* this past year. This information is required by program regulations and is kept strictly confidential.

Number of people living in home: _________

Social Security	$ _______________
SSI	$ _______________
Pension/Retirement	$ _______________
Investments	$ _______________
Alimony	$ _______________
Unemployment/Workers Comp	$ _______________
Interest and dividends, Rent	$ _______________
Other (Explain)	$ _______________

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Office Use Only

Do you expect to pay for out-of-pocket medical expenses this year? They can be medical premiums, medicines, doctor's visits, and ANY cost that is NOT reimbursable by a health/medical insurance program. Yes or No

I understand that false or misleading information given may result in discharge from the program.

____

Name Date

Rev. 4/2017