Jewish Family SERVICES

Life Plan Financial Needs Assessment

Grant Source: ❒CSS ❒CFJS ❒JFS/SE

Name: _____DOB: ____/_____/____ Today's Date: ____/_____/____

Total monthly income: _____ Source(s): _____

Current or prior financial assistance from other Jewish agencies: _____

Other resources (non-Jewish agency support, CATS/STS, Food Stamps, etc.): _____

_____

Medicare? ❒Yes ❒No **Supplement? _____Medicare ID:_____**

Medicaid? ❒Yes ❒No **ID #:_____ Disability?** ❒Yes ❒No **LTC Insurance?** ❒Yes ❒No

Total value of assets (home, car, bank accounts, IRA, etc.): _____

Monthly Expenses

Item	Amount Paid
Rent/Mortgage (incl. taxes)	
Electric	
Gas/Bus Fare, Etc.	
Water	
Groceries	
Dining Out	
Telephone (wireless/home phone)	
Internet	
Cable	
Car Payment	
Car Insurance	
Car Maintenance	
Medical/Health/Dental Insurance	
Prescription Costs	
Other Medical Hardships	
Home Owner's/Renters Insurance	
Home Owners Association Dues	
Life Insurance/Other Insurance	
Membership (JCC, Temple, etc.)	
Clothing	
Pet Expenses	
Credit Card	
Bank Loans/Other Loans	
Other	
Total Monthly Expenses	