MONTHLY PAYMENT PLAN DETERMINATION FOR SERVICES PROVIDED BY:
THE COUNSELING CENTER OF THE OZAUKEE COUNTY HUMAN SERVICES DEPARTMENT

This is a statement of financial condition that must be completed to request consideration of special circumstances that may justify a monthly payment plan for services received. This request may be made if a person believes that the normal obligation to pay for services would create a clear hardship on the person and/or family. Additional documentation may be required to verify the accuracy of the information that you have given.

This statement of financial condition form must be requested, completed, and returned to the Ozaukee County Department of Human Services Counseling Center during the first month of services.

Note: Shaded items are to be filled in by office staff, not applicant.

CLIENT NAME Last – First – MI		CLIENT No. (Office staff)		BIRTHDATE – month / day / year	
RESPONSIBLE PARTY (If different from client)		# of Legal Dependents (Including yourself)		Maximum Monthly Payment Liability: $________________________________	
Social Security No.	HOME ADDRESS	CITY	STATE	ZIP	HOME PHONE ( )

ASSETS

Type of Asset:	Location or description:	Value	Mortgage	Monthly Payments	Mortgage Holder
1. REAL ESTATE Home					
2. Other Real Estate					
3. **PERSONAL PROPERTY** Savings					
4. Stocks and Bonds (Market Value)					
5. Life Insurance (Cash Value)					
6. Retirement Funds and Annuities (Accessible)					
7. Automobile(s)					
8. Snowmobile(s), Motorcycle(s), etc.					
9. Boats, Campers, etc.					
10. Livestock					
11. Machinery					
12. Miscellaneous					

DEBTS

Creditor (To whom money is owed)	Amount Due	Monthly Payments
13.		
14.		
15.		
16.		
17.		
18.		
19.		

Creditor (To whom money is owed)	Amount Due	Monthly Payments
20.		
21.		
22.		
23.		
24.		
25.		
26. Total Amount Owed and Total Monthly Payments		

NOTE: The second side of this application must also be completed and signed.

Revised: 2/25/21

MONTHLY BUDGET	
ITEM	Monthly Payment
27. Rent	
28. Mortgage Payment (If not included in total debt payments on line 26.)	
29. Food	
30. Heat	
31. Electricity	
32. Water	
33. Telephone	
34. Clothing	
35. Debt Payment (Total from line 26)	
36. Automobile: Gas & Oil	
37. Automobile: Upkeep & Repairs	
38. Insurance: Automobile	
39. Insurance: Life	
40. Insurance: Health & Accident	
41. Insurance: Home	
42. Insurance: Other	
43. Real Estate Tax – if not paid with mortgage	
44. Union Dues	
45. Employment Expenses – if not reimbursed	
46. Medical and Dental Expense	
47. School Expense	
48. Other Transportation Expense	
49. Miscellaneous	
50.	
51.	
52.	
53. **Total Expenses**	$

MONTHLY NET INCOME	
ITEM	Net Income After Taxes
54. Wages of Patient	
55. Wages of Spouse	
56. Wages of Mother – if patient is a minor	
57. Wages of Father – if patient is a minor	
58. Rental Income	
59. Social Security Benefits	
60. Veterans' Administration Benefits	
61. Supplemental Security Income (SSI)	
62. Retirement Income	
63. Interest & Dividends	
64. Alimony & Support	
65. Unemployment Compensation	
66. Workmen's Compensation	
67. Other Income	
68.	
69.	
70.	
71.	
72.	
73.	
74.	
75. **Total Net Income**	$

Financial Summary

76. Total Net Income - **from line 75.**	
77. Total Expenses - **from line 53.**	
78. **Surplus or (Deficit)**	$

I guarantee the accuracy of the information provided on this application form.

Signature of the Client (or Legal Guardian): ________________________________ **Date**: ___________

DECISION OF THE DEPARTMENT CONCERNING THIS REQUEST:

Office Services Supervisor: ____ **Date:** _________________
(Signature)