OTHER EXPENSES WORKSHEET

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HUMAN SERVICE CENTERS
SFN 489 (2-2024)

Clear Fields

Client Identification

Complete the monthly or yearly amount column

Housing Expenses (describe type for other amounts)	Monthly Amount	Yearly Amount
House Payment /Rent Payment (include taxes and insurance)		
Utilities (Heat, Lights, Water, TV, Telephone)		
Other		

Vehicle Expenses (describe type for other amounts)		
Loan Payment (number of cars)		
Gas		
Repairs		
Insurance		

Child Support and Alimony Payments		
Child Support Payment		
Alimony Payment		

Daycare and Nursing Home Expenses		
Child Daycare (only for work or school)		
Nursing Home Expenses		

Medical Payments (describe type for other amounts)		
Insurance Premiums (Medical Assistance, Medicare, Blue Cross Blue Shield)		
Dental /Vision (Eyeglasses/Contacts)		
Prescriptions		
Other		

Other Expenses (describe type for other amounts)		
Food		
Clothing		
Credit Card(s)		
Other		
Total Expenses		

I hereby certify that the amounts listed above are true to the best of my knowledge. I understand that if any information is willfully withheld, the Human Service Center will charge FULL FEE for the services provided.

Signature of Responsible Party or Legal Representative	Relationship	Printed Name