

Self-Declaration of Income

Client Name: _____

Date: _____

Date of Birth: _____

MRN#: _____

Complete the information below only if you have no other way to document your income. All of the boxes below must be checked and all questions answered.

- I am paid in cash.
- I do not receive pay checks.
- I do not receive pay stubs.
- I cannot obtain a letter from my employer. Explain why: _____

Describe what kind of work you do: _____

Complete the following information regarding your monthly income:

Last three (3) months	Income
	\$
	\$
	\$

My average per month is \$ _____

I understand I must submit a copy of the Social Security Income Verification / Third Party Query (TPQY) form within forty-five (45) days of this declaration (Broward RW Eligible Patients).

Read the following and sign below

I certify that I have no other way to document my income and that all of the above information is true and correct. I understand that this information is to be used to determine my eligibility for this program.

Client Printed Name

Client Signature

Date:

Staff Printed Name

Staff Witness Signature

Date: