To be used when it is not possible to provide proof of earnings, i.e., collects and sells metal, flea market sales, yard sales, yard work, roadside stands, etc.

MAP | Medication Assistance PHARMACY
A WELVISTA PROGRAM

Self-Declaration of Income

Verification of Household Income for Patient: _____
Printed Name

By my signature, I attest that I have been working and receiving payment for the following. I do not have any income documentation, and it is not possible to have the people who have paid me provide a letter.

Type of work: _____

Amount Received: $_____ (Circle one) Per Week Bi-Weekly Month

Wage Earner Name (Please Print):_____

Wage Earner Signature: _____ Date: _____

For the person who can verify the patient's household income:

By my signature, I verify that the income statement signed above is true and accurate.

Name of Verifying Person (Please Print): _____

Signature (Required): _____ Date: _____

NOTE: Both the applicant and the person verifying the income MUST SIGN this statement. The completed form must be submitted with the Medication Assistance Pharmacy Application.