No Income Form

NOTE: USE THIS FORM ONLY IF NO ONE IN THE HOUSEHOLD HAS INCOME
Patient must complete SECTION 1 – Person helping the patient must complete SECTION 2.
Completed form must be submitted with Medication Assistance Pharmacy application packet.

SECTION 1 – Patient Information (All information is required)

By signing this form, I certify that neither I nor any member of my household has income.

Patient Name (Please Print):_____

Patient Signature: _____ Date: _____

SECTION 2 – Person helping patient (All sections must be completed, including dollar amounts.)

We need to know how the patient is living day to day (housing, food, and utilities).
The person helping the patient cannot live in the same house as the patient.

By my signature, I verify the above patient's current housing situation, that all information is true, and that no work or services are given in exchange for support.

Name of the person helping or verifying patient living situation: _____
(Printed Name)

Benefits Verification: If patient or any member of the household receives SNAP/Food Stamp benefits, HUD housing assistance, or other public assistance, please attach current documentation for each benefit received.

Please list the dollar amount patient has received in the last 30 days for each item below that applies:

$_____House/Rent (if answer is $0 state why): _____
$_____Food (if answer is $0 state why):_____
$_____Utilities (if answer is $0 state why): _____

$_____Total amount given to patient per month

_____Date: _____
(Signature of person helping or verifying patient living situation)

Or- ___Patient has no one over age 18 to vouch for their current living situation:

_____Date: _____
(Patient Advocate/Case Manager)