Patient Income Verification Form

Patient Name_____

Employer _____

Source of Income:

* Patient's salary, wages, etc. _____
  Verified by Pay Stub? Yes____ No____
* Business Profits _____
* Alimony, child support _____
* Significant other, relatives, friends _____
* Retirement _____
* Social Security _____
* Public Assistance, welfare _____
* Veteran's Administration _____
* Unemployment Compensation _____
* Other income readily available _____
  Please specify:

Total Gross Monthly Income **$_____**

Number of wage earners in household_____

{Divide Gross Monthly Income by number of major wage earners in the household ~ this determines patient's income}

Patient's Determined Income **$_____**

Number of Persons in Household_____

I have read and understand the above and declare the information furnished by me to be true and complete to the best of my knowledge. I will notify the agency of any changes in my income, resources, or family composition. I also understand that this information will be treated in a confidential manner in accordance with Washington State Law.

_____ _____

Patient Signature Date

_____ _____

Witness Date