HealthySF
OUR HEALTH ACCESS PROGRAM

SF COUNTY PROGRAMS
INCOME STATEMENT

Applicant Last Name: _____ First Name:_____

Birth date: _____

I have a job. However, my employer pays me in cash only. I do not get a paycheck that can prove my wages. This is how much I have made in the last 3 months:

$_____ for _____ (month/year)

$ _____ for _____ (month/year)

$ _____ for_____(month/year)

I declare the information I have given is true and correct to the best of my knowledge. I understand the information given will be used to check if I can get various federal, state, and county programs. I understand that if the information I have given is found to not be true, I might have to pay the full amount of any bills for medical services I get.

Applicant Signature Date