GOVERNMENT OF THE UNITED STATES VIRGIN ISLANDS

DEPARTMENT OF HUMAN SERVICES

VI STATE PHARMACEUTICAL ASSISTANCE PROGRAM

INCOME INFORMATION

Date___________________________

I.D. NUMBER__________________

NAME OF CLIENT ____

INCOME INFORMATION:

Wages/Salary/ Tips $___________________________________

Profit from Self Employment $ ___________________________

Interest from Savings Accounts $ _________________________
Interest from Certificates of Deposits (CD'S) $ ______________
Other Interest Income and Dividends ______________________

Pair Market Rental $ ________________________________
Other In-kind Income $______________________________
____
____

Rental Income $ _______________________________
Unemployment Insurance $_____________________
Workmen's Compensation $_____________________
Veteran's Compensation $_____________________
Social Security $_____________________
Pensions, Annuities &
Private Insurance $ ____________________________
____
____
____

TOTAL INCOME $ _________________________________

CIVIL RIGHTS CLAUSE:

No person shall, on the grounds of race, color, sex or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under this program.

Please be aware to recertify

I certify that the information given is true and correct.

Client's Signature: ______________________________

Employee's Signature____________________________

Director's Signature _____________________________