



Volunteers in Medicine  
of Southern Nevada

## PATIENT INCOME STATEMENT

PATIENT'S NAME: \_\_\_\_\_

PATIENT Income	Weekly	Monthly	Employer/Agency
Salary/Wages			
Child Support			
Social Security Income			
S.S. Disability			
S. S. Retirement			
Retirement/Pension			
Unemployment			
Food Stamps			
Worker's Comp			
Other			
<b>TOTAL INCOME:</b>			

TOTAL ANNUAL INCOME: \_\_\_\_\_

HOUSEHOLD Income	Amount per Month	Household Member	Relationship to Patient
Salary/Wages			
Child Support			
Social Security Income			
S.S. Disability			
S. S. Retirement			
Retirement/Pension			
Unemployment			
Food Stamps			
Worker's Comp			
Other			
<b>TOTAL INCOME:</b>			

TOTAL ANNUAL INCOME: \_\_\_\_\_

**Medicaid Eligibility:** Applied \_\_\_\_\_ Denied \_\_\_\_\_ Pending \_\_\_\_\_ Accepted \_\_\_\_\_  
Date Date Date Date

**DECLARATION OF NO INCOME**

PERIOD OF TIME WITH NO INCOME: \_\_\_\_\_

Please describe how you meet your monthly expenses for food, shelter and utilities:

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**I CERTIFY THAT THE INFORMATION STATED IS TRUE AND ACCURATE BY SIGNING THIS FORM:**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_