NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

Self Declaration of Income

MVP HEALTH PLAN USE ONLY

Head of Household Name: _____ FEEA App ID: _____

Name: _____ App. Reg/Case #: _____
(DSS Use Only)

Social Security Number: XXX-XX-____

Address: _____
STREET

_____ _____ _____
CITY STATE ZIP CODE

Complete the information below only if you have no other way to document your income.
All of the boxes below must be check and all questions answered. Failure to complete this form may result in denial of your application.

- ☐ I get paid in cash.
- ☐ I do not get pay checks.
- ☐ I do not get pay stubs.
- ☐ I cannot get a letter from my employer. **Explain why:** _____

_____

My cash income is $ _____ How often (weekly, monthly etc.) _____

Current Employer: _____

Applicants/Recipients must read the following and sign below

I certify that I have no other way to document my income and that all of the above information is true and correct. I understand that this information is to be used to determine eligibility for Public Health Insurance Programs. I understand that program officials may verify information on this form. I also understand that if I intentionally misrepresent my income, I may have to repay benefits received and may be prosecuted under State law.

Signature of Applicant: _____ Date: _____

Facilitated Enrollers must read the following and sign below

I certify that I asked the applicant/recipient about all sources of income received by the household and, before using this form, used best efforts to obtain other possible sources of documentation. The information reported on this form was provided solely by the applicant/recipient and reflects the income the applicant reported to me. I did not modify the information in any way. I understand that if I intentionally falsified information on this form or if I assisted the applicant in falsifying any information, I may lose my job and may be prosecuted under State law.

Name: _____ Signature: _____ Date: _____