Emergence Health Network

Income Attestation Form

To be used when proof of income is not available:

To comply with Emergence Health Network's proof of income requirements, I verify the following information:

I, _____ (first and last name) currently do not have any proof of income, but I am requesting services for the sole purpose of Treatment and Recovery Support Services. I state that I have no income, and hereby certify that I do or do not receive income from any of the following sources.

Income Source	
Wages from employment (including commission, tips, bonuses, fees, etc.)	☐ Yes ☐ No
Income from operation of a business	☐ Yes ☐ No
Rental income from real or personal property	☐ Yes ☐ No
Interest or dividends from assets	☐ Yes ☐ No
Social Security, annuities, insurance policies, retirement funds, pensions, or death benefits	☐ Yes ☐ No
Unemployment or disability payments	☐ Yes ☐ No
Public assistance payments	☐ Yes ☐ No
Periodic allowances such as alimony, child support or gifts received from persons not in the household	☐ Yes ☐ No
Sales from self-employed resources	☐ Yes ☐ No
Any source not named above	☐ Yes ☐ No
I am not employed at this time and do not have any reportable source of income	☐ Yes ☐ No

I understand that Emergence Health Network requires verification of income to determine eligibility of services. It has been explained to me that if I do not meet the income guidelines by the Texas Department of State and Health Services, I will be responsible for paying for the services identified because of my screening and use my insurance benefits.

I understand that it is my responsibility to report any change in income, from any source, within 15 days after such a change. I verify that all statements regarding my income are true, and I understand that false, misleading, or incomplete information may result in termination of services.

_____ _____

Client Signature Date

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Staff Date