



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 _____