Sandoval County Healthcare Assistance Program

VERIFICATION OF INCOME

Health Care Assistance Program Applicant Name: _____

_____

(Applicant/Relative/ Friend or Advocate Address)

_____

(City) (State) (Zip Code) (Phone Number)

If Applicant is working for cash, indicate the amount:

_____ _____

(Weekly Amt.) (Monthly Amt.)

If Relative/Friend or Advocate is providing assistance, indicate the amount:

_____ _____

(Weekly Amt.) (Monthly Amt.)

If Relative, Friend or Advocate, please explain the financial arrangement you have with the applicant:

_____

_____

Print Name: _____
(Applicant)

Signature: _____ **Date: _____**
(Applicant)

Print Name: _____
(Relative/Friend or Advocate)

Signature: _____ **Date: _____**
(Relative/Friend or Advocate)

STATE OF NEW MEXICO)
) SS.
COUNTY OF SANDOVAL)

The foregoing was acknowledged before me this _____day of _____,

by _____

Notary Public _____My Commission Expires _____