DECLARATION OF INCOME OR SUPPORT

The City of New York
Human Resources Administration
Medical Assistance Program
MAP-2050A .....Rev. 08/01/06

Name:_____ Case Number:_____

Address: _____

INCOME **To be completed by the consumer** if you have no other means to document your income. **All of the boxes below must be checked and all questions answered.**

Failure to complete this form in full will result in deferral or rejection of your application for Public Health Insurance.

☐ I get paid/tips in cash ☐ I did not file a tax return last year ☐ I do not get pay stubs ☐ I do not get paychecks

☐ I cannot get a letter from my employer ***(explain why)*** _____

My cash income is $_____How often *(weekly, monthly etc)* _____

Current Employer _____Phone Number _____

Employer Address_____

Does current employer offer health insurance? ☐ Yes ☐ No

Applicants must read the following and sign below

I certify that I have no other way to document the above 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 all 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 subject to prosecution under State law.

SIGNATURE OF APPLICANT	RELATIONSHIP TO PERSON ABOVE	SOCIAL SECURITY NUMBER **(If none, write "NONE").**	DATE

FOR OFFICIAL USE ONLY

Facilitated Enrollers and Third Party Representatives must read the following and sign below

I certify that I asked the applicant 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 and reflects all 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 that I may be prosecuted under State law.

Print Name: Signature: Date:

SUPPORT **To be completed by the person who provides support.** Please complete this section so that the Medical Assistance Program can determine eligibility for Public Health Insurance.

Name: *(Print)*_____Address: _____

Phone Number: _____Relationship to person you provide support_____

I provide the following: (*Check all that applies*)

☐ Sleeping accommodations ☐ Meals ☐ Monthly cash assistance $_____

I have provided the support indicated above since_____ and ☐ **Will continue** ☐ **Will not continue** to do so.

I ☐ do ☐ do **not** provide medical and hospital expenses.

Signature of person providing support: _____ Date_____

Applicants must read the following and sign below.

I understand that program officials may verify information on this form.

Signature of applicant: _____Date: _____