Self Employment Income Form

For use with Medicaid applications

Applicant Name _____ **Date** _____

Case Number _____ **Date of Birth** _____

Home Address _____

Mailing Address _____

Phone Number _____ **Email** _____

This form is used to report self-employment income and expenses if you are unable to provide a recent tax return from the previous year. Please complete the income and expense table for the past 6 months, beginning with the date your Medicaid application was first submitted.

Attach proof of income and expenses when available. Acceptable documentation includes:

REQUIRED DOCUMENTATION

- Receipts or invoices for services provided
- Bank statements showing deposits or withdrawals
- Expense receipts (supplies, equipment, utilities, etc.)
- Other proof of self-employment income or expenses

If additional space is needed, you may attach extra sheets of paper or additional copies of this form.

Once all fields have been filled out, the form may be submitted in-person, by email, or by mail.

Business Information:

*IF APPLICABLE

Business/Trade Name* _____

Type of Business/Service _____

Business Address* _____

Tax ID/EIN* _____

Household Information:

Do other household members contribute to this business income? ☐ Yes ☐ No

If yes, list names: _____

AND **Each contributing household member must complete a separate self-employment income form with their contribution amount.**

Reporting Period:
This form covers income/ expenses from the following start and end dates.

Start Date

End Date

Note: Gross Income – Total Expenses = Net Pay (Total Net Income Earned)

Date	Description of Service(s) Provided	Gross Income	Description of Expense(s) Paid	Total Expenses	Net Pay

Total Gross Income	Total Expenses	Total Net Pay (Net Income)

Client Prejury Statement:

I, _____, hereby declare that I am self-employed and earn approximately $ _____ ☐ Weekly ☐ Bi-weekly ☐ Monthly or other _____ from my self-employment.

Under penalty of perjury, I certify that the information presented in this document is true and accurate to the best of my knowledge. By signing below, I understand that providing false statements may result in termination, denial, or recovery of benefits.

Client Printed Name _____

Client Signature _____ **Date** _____

OR

Authorized Representative Name _____ **Date** _____

Authorized Representative Signature _____

Phone Number _____ **Email** _____

FOR OFFICE USE ONLY

Received by: _____ Date: _____

Disclaimer: We do not discriminate on the basis of race, ethnicity, color, national origin, religion, sex, age, or disability. Free language assistance services are available for people whose primary language is not English. We also provide free aids and services to assist with communicating the information effectively (such as interpreters, captioning, Braille, or large print). If you need these services, please contact us by phone or email.

St Thomas/St. John District: 340-774-0930 ext. 4104 or sttjmap@dhs.vi.gov | St. Croix: 340-772-7100 or stxmap@dhs.vi.gov

Privacy Notice: The information provided on this form will be used only for purposes of determining and verifying Medicaid eligibility. Your information is protected under state and federal privacy laws.