Rockbridge Area Health Center

Self-Employment Verification Form

Legal Name: _____ **Birth Date:** _____

Business Name:_____

Business Address (if different from mailing): _____

Business Telephone #: _____

Instructions: Self-employment is defined if any of the following apply: the patient carries on a trade or business as a sole proprietor or an independent contractor, is a member of a partnership that carries on a trade or business or is otherwise in business for them self (including a part-time business). This form is to record self-employment profit after business related expenses are deducted. Use this form when the current 1040 is not available.

Self-Employment Income from the last 90 days:

Date Received	**Source:** (Include name of customer or Job)	**Amount Received**

Self-Employment Expenses from the last 90 days:
Expenses include, but are not limited to, the cost of labor, materials, supplies and vehicles, etc.

Date	**Type of Business Related Expenses:**	**Amount Paid**

Net Profit (Income minus Expenses)

Amount

I understand Rockbridge Area Health Center may contact me to verify this information. Furthermore, I understand providing false information or information subsequently determined to be false will result in the applicant's eligibility for SFDP discounts to be revoked and the full balance of the account(s) restored and payable immediately. This information is confidential and only used to determine your eligibility for the Sliding Fee Discount.

Applicant Signature:	Date:

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