HEALTHWELL FOUNDATION®
When health insurance is not enough.®

Income Verification Statement

Upload through Portals or Fax to 800-282-7692

Patient Name: _____ HealthWell ID: _____

Last 4 digits of SSN: xxx-xx-_____ Date of Birth: _____

Patient Contact Number for Income Questions: _____

Please list the income source and amounts of income for **ALL** family members including yourself. If a family member does not contribute to the income, please indicate zero in the amount field.

PLEASE ATTACH SUPPORTING DOCUMENTATION FOR ALL INCOME:

Family Member Name	Relationship	Income Source	Amount	Frequency		
				Weekly	Monthly	Yearly
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐

Include all earnings and benefits received, but not limited to:

- Wages
- Unemployment
- Pension
- IRA
- Dividends
- Alimony
- Social Security Income (SSI)
- Social Security Disability (SSID)
- Workers Compensation
- Aid to Families with Dependent Children (AFDC)/Temporary Aid to Needy Families (TANF)
- Rental Property Income
- Interest Income
- Investment Account
- Charities/Grants/Gifts
- Other Income (Please Explain)

Attach a SIGNED copy of your 1040 tax return from the previous year. If you filed an extension, please send a copy of the letter.

If the attached documentation does not reflect your current financial situation, please provide a letter explaining how your income has changed and any extenuating circumstances. In addition to the required income documentation, you may also attach a list of monthly medical expenses.

By signing below, I certify that all the information I have provided is true and that I have not neglected to inform the HealthWell Foundation of any additional income.

X _____ _____

Patient Signature (REQUIRED) **Date (REQUIRED)**