NEW YORK STATE DEPARTMENT OF HEALTH

Bureau of Medicaid and Family Health Plus Enrollment

Financial Status (Farm or Business)

TO BE COMPLETED BY APPLICANT

APPLICANT'S NAME (First) (M.I.) (Last)	BUSINESS NAME
APPLICANT'S ADDRESS	BUSINESS ADDRESS
APPLICANT'S TELEPHONE NO. ( )	BUSINESS TELEPHONE NO. ( )

Note: Depreciation*, personal expenses and entertainment, personal transportation, purchase of capital equipment and payments of the principals on loans are **NOT** allowable deductions. Losses from previous years are also **NOT** deductible. (*Allowed for SSI-R applicants/recipients)

I. BUSINESS INCOME (last three months)	**MONTH ONE** _____ / _____ (mm) (YY)	**MONTH TWO** _____ / _____ (MM) (YY)	**MONTH THREE** _____ / _____ (MM) (YY)
1. Gross Sales			
2. Inventory Purchases			
3. Gross Income (line 1 minus line 2)			
II. BUSINESS EXPENSES	DEDUCTIONS	DEDUCTIONS	DEDUCTIONS
4. Telephone	**$**	**$**	**$**
5. Supplies			
6. Heat/Utilities			
7. Advertising			
8. Interest			
9. Insurance			
10. Bank Charges			
11. Repairs			
12. Business Taxes			
13. Business Vehicle Expenses			
14. Business Rent A. Property B. Equipment	_____	_____	_____
15. Other Expenses (Specify)			
III. INCOME SUMMARY	SUMMARY	SUMMARY	SUMMARY
16. **Total Business Expenses** (lines 4 thru 15)			
17. NET INCOME (Line 3 minus line 16)	17a	17b	17c

TO BE COMPLETED BY LOCAL DEPARTMENT OF SOCIAL SERVICES WORKER

THREE-MONTH TOTAL NET INCOME (line 17a + line 17b + line 17c)	THREE-MONTH AVERAGE NET INCOME (line 18 divided by 3)
MONTH ONE (17a) $_____ MONTH TWO (17b) $_____ MONTH THREE (17c) $_____ 18. THREE MONTH TOTAL $_____	THREE-MONTH TOTAL $_____ (line 18) / 3 = _____ THREE-MONTH AVERAGE

Applicants must read the following and sign below

I certify that I have no other way to document the above self-employment 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.

Applicant's Signature	Date Signed	Worker's Signature	Date Signed