

# ZERO INCOME STATEMENT

## Vermont Medication Assistance Program (VMAP)

I, \_\_\_\_\_, have applied for the Vermont Medication Assistance Program (VMAP) through the Vermont Department of Health. Federal/State regulations require verification of all income from applicants household.

Income includes but is not limited to:

- Gross wages, salaries, overtime pay, commissions, fees, tips and bonuses
- Net income from operation of a business or from rental or real personal property
- Interest, dividends and other net income of any kind for real personal property
- Periodic payments received from Social Security, annuities, insurance policies, retirement funds, pensions, disability or death benefits and other similar types of period receipts
- Payments in lieu of earnings, such as unemployment and disability compensation, worker's compensation, and severance pay
- Public assistance
- Alimony and child support payments (whether through the court system or not)
- Regular pay, special pay and allowances of a head of household or spouse who is a member of the Armed Forces (whether or not living in the dwelling)

I have stated during this verification process that I have no income at this time. I have not received income since \_\_\_\_\_. I do not expect to receive any income until \_\_\_\_\_. I applied for \_\_\_\_\_ (other financial assistance) on \_\_\_\_\_ (date).

***I understand that any misrepresentation of information or failure to disclose information requested on this form may disqualify me from participation in this program, and may be grounds for termination of assistance.***

I certify that the above information is true and correct. I also understand that it is my responsibility to report all changes to my household composition or income in writing to within ten (10) business days of such change.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Medical Case Manager Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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| Medical Case Manager's Notes: |
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