# ZERO INCOME AFFIDAVIT

I, _____, have applied for services with the Interior AIDS Association. Program regulations require verification of all income from participating households.

Income includes but is not limited to:

● Gross wages, salaries, overtime pay, commissions, fees, tips, and bonuses

● Net income from operation of 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

● Lump sum payment(s) for the delayed start of a periodic payment (except as provided in 24 CFR 5.609(b) (5))

● Payments in lieu of earnings, such as unemployment and disability compensation, workers compensation, and severance pay

● Public Assistance

● Alimony and child support payments (Whether through 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)

● Regular monetary gifts from family and/or friends

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 IAA's HIV Client Services program, and may be grounds for termination of assistance. WARNING: It is unlawful to provide false information to the government when applying for federal public benefit programs per the Program Fraud Civil Remedies Act of 1986, 31 U.S.C 3801-3812.***

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 within ten (10) business days of such change.

Signature: _____ Date: _____

Witness: _____ Date: _____

Case Manager/Care Coordinator's Notes:

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