

Richmond County



Pharmacy Assistance  
Program

## Self-Employment Form

This form should be used by patients who have regular or steady income and are paid in cash.

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Title: \_\_\_\_\_

Business Name (If applicable): \_\_\_\_\_

I have attached:

- Invoices/Receipts
- Letter from those who pay in cash
- Bank Statement

Please indicate your gross monthly income: \$ \_\_\_\_\_

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

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