

SELF-EMPLOYMENT INCOME STATEMENT
 Michigan Department of Health and Human Services
 Michigan Drug Assistance Program

Provide all requested information about your household's self-employment income for the last **30 days** and submit proof of business legitimacy.

SECTION I: DEMOGRAPHICS

Client's First Name		Client's Last Name		MIDAP Number	
Business Name		Type of Business		Owner's Name	
Business Address			City		State Zip Code

SECTION II: INCOME

Source of Income	Date Income Received	Amount
		\$
		\$
		\$
		\$
		\$
Total Income		\$

SECTION III: CERTIFICATION

By signing this form, I hereby certify this information to be accurate and true.

Applicant's Printed Name		Applicant's Signature		Date
Case Manager (if applicable)				

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.