Texas Self-Directed Care

INCOME INFORMATION

Name: _____ **Date:** _____

TXSDC ID: _____

Insurance Type:

_____ Medicaid

_____ Medicare (List type- Part A, B or both)

_____ VA Benefits

_____ Other

Annual Income from Source

Income Type:

SSI (provide award letter) _____

Disability (provide award letter) _____

VA Benefits (provide award letter) _____

Child Support
(provide check stubs or copy of court order) _____

Employment Wages
(provide pay stubs or most recent W-2) _____

Other Government Subsidies
(provide any award letters or check stubs) _____

Other Income
(please provide any relevant documentation) _____

Total Annual Income _____

I hereby certify that the above information is true to the best of my knowledge and have supplied corresponding documentation.

_____ _____

Participant Signature Date

_____ _____

SDC Advisor Signature Date

*(PLEASE OBTAIN COPIES OF INSURANCE AND INCOME SOURCES)