



Return form by Mail, Fax, or Email to:
NC MedAssist
4428 Taggart Creek Rd, Suite 101
Charlotte, NC 28208
Fax: 704-536-9865 | Email: info@medassist.org

Migrant Farmworker Income Verification Form

I am sending this letter on behalf of our patient _____ DOB _____ with his/her application for prescription assistance. This patient currently does not have a way to verify his/her income due to the nature of his/her employment as a farmworker. He/She does not receive a pay stub that qualifies as proof of income. Please consider my attestation to their income, as follows, in processing their application.

Income Information:

Pay Rate: \$ _____/hr \$ _____/week \$ _____/month \$ _____/year

Pay Period(circle one): Weekly Bi-weekly Bi-monthly Monthly

Enrollment Site/Organization Name: _____

Authorized Employee Signature: _____ **Date:** _____