



### Wellness Assistance Verification Form

Full Legal Name: \_\_\_\_\_

Address, City, State, Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Emergency Contact Name & Phone number: \_\_\_\_\_

**Please list all members of the household:**

	Full legal name	Age	Relationship
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

**Please list all pets in household:**

	Pet's name	Age	Species	Breed	Weight	Altered (Y/N)
1.						
2.						
3.						

**Program qualifications:** Acceptable proof of income documents to qualify for the reduced costs associated with HSSA's Wellness Program include at least one of these: two paycheck stubs with dates from the last month of each wage earner; government award letter showing the amount of Social Security, Supplemental Security, Pension, Retirement, Survivor's Benefit, Disability; W2 or tax documentation for the previous year; AHCCCS; Food Stamps; EBT.

Gross Income Qualification Guidelines:

#of persons in hh	Annual Income to Utilize Wellness Fees
1	\$16,132
2	\$26,438
3	\$36,299
4	\$44,809
5	\$52,876
6	\$61,845
7	\$70,814
8	\$79,783

For each additional person, add \$8,969

**Proof of Income (please attach to this document):** \_\_\_\_\_  
\_\_\_\_\_

**I certify that all above information is true and accurate.**

**Print name:** \_\_\_\_\_

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

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