

Self-Employment Verification Report- Itemized

Sole Proprietorship

HW2020 | Rev 08/2014

Case Name:		Case Number:
Participant Name (If different than Case Name):		Social Security Number:
Business Name:	Business Address:	
Business Phone:	Type of Business:	
Was this business started within the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how many months has the business been in operation?	Income Months: (e.g., 01/07-06/07)

Instructions: Complete the following sections to verify your self-employment information for the tax year or number of months your business was in operation (recorded above). The information you provide is used by the Idaho Department of Health and Welfare (IDHW) to calculate self-employment income and deductions according to IDHW regulations.

Part I: Income		
1.	Gross Receipts or Sales	
2.	Net Profit from Sale of Assets (Capital Gains)	+
3.	Total Part I: (add line 1 and 2)	\$

Part II: Cost of Goods Sold		
Cost of Goods Sold is the amount expended to produce or manufacture merchandise sold, including material and labor used to produce products for sale and products purchased for resale (less ending inventory of items not sold), during the tax year or number of months the business was in operation (recorded above).		
4.	Cost of Goods Sold	Total Part II: \$

Part III: Gross Income		
5.	Total of Part I (line 3)	
6.	Total of Part II (line 4)	-
7.	Total Gross Income: (subtract line 6 from line 5)	\$

Instructions: Complete the following section to verify your self-employment expenses for the tax year or number of months your business was in operation (recorded on page 1 of this form).

Part IV: Expenses		
8.	Advertising	
9.	Chemicals	
10.	Contract Labor/Labor (non-household members)/ Customer Hire	
11.	Feed	
12.	Fertilizers	
13.	Freight/Trucking	
14.	Insurance/Worker's Compensation	
15.	Interest on Business Loans	
16.	Legal/Professional Services	
17.	Materials/Goods/Supplies	
18.	Office Expenses	
19.	Rent/Tax on Business Property	
20.	Repairs and Maintenance	
21.	Seeds/Plants	
22.	Tax and License Fees	
23.	Utilities/Phone	
24.	Vehicle Expense/Mileage (not to and from home)	
25.	Veterinary	
26.	Depreciation (allowable for HCA and AABD Cash programs only)	
27.	Other (please indicate the type of expense)	
28.	Other (please indicate the type of expense)	
29.	Total Part IV:	\$

Part V: Gross Income		
30.	Total of Part III (line 7)	
31.	Total of Part IV (line 29)	-
32.	Total Net Income: (subtract line 31 from line 30)	\$

Signature

Under penalty of perjury, I swear or affirm the information I have reported is true and complete.

Signature of applicant/authorized representative Phone Date

This Section for Office Use Only.	
Projected Monthly Gross Income	