Statement of Income

Unless you have been told otherwise, you have two options: Attach your paystubs and receipts **OR** Fill in the information below and keep your paystubs and receipts in case we ask to see them in the future.

Name	Member ID	Office ID	Case Owner	Income Change ☐ YES ☐ NO

MAIL THIS FORM TO THE ADDRESS BELOW AS SOON AS POSSIBLE AFTER DAY MONTH YEAR

INCOME FOR DAY MONTH YEAR TO DAY MONTH YEAR

Have ☐ you ☐ your spouse ☐ dep. adult ☐ stopped ☐ started working this month?

Name of Employer or Paid Training Program

Date of ☐ last ☐ first pay cheque _____

Earnings

1. Complete payment information for each family member who is employed or in a paid training program
2. If applicable, enter any deductions

Name: _____ ☐ Recipient ☐ Spouse ☐ Dep. Adult Attending secondary/post-secondary school full time? ☐ No ☐ Yes	Employer Name/ Training Program Date	Employer Name/ Training Program Date	Employer Name/ Training Program Date	Employer Name/ Training Program Date	Employer Name/ Training Program Date
	Amount	**Amount**	**Amount**	**Amount**	**Amount**
Gross pay (before deductions)					
Net pay (after deductions)					
Deductions (enter only if applicable)					
Child or spousal support payments					
Other garnishments to repay a debt					

Name: _____ ☐ Recipient ☐ Spouse ☐ Dep. Adult Attending secondary/post-secondary school full time? ☐ No ☐ Yes	Employer Name/ Training Program Date	Employer Name/ Training Program Date	Employer Name/ Training Program Date	Employer Name/ Training Program Date	Employer Name/ Training Program Date
	Amount	**Amount**	**Amount**	**Amount**	**Amount**
Gross pay (before deductions)					
Net pay (after deductions)					
Deductions (enter only if applicable)					
Child or spousal support payments					
Other garnishments to repay a debt					

Child Care Expenses

1. Enter the child name and child care provider name
2. Select the type of child care, licensed (most day cares) or unlicensed (most babysitters) and enter the amount

Child name	Child care provider name	Licensed	Unlicensed	Amount
		☐	☐	
		☐	☐	
		☐	☐	

I declare the information here to be accurate and complete. Signature (Recipient/Trustee) Date

Notice with Respect to the Collection of Personal Information

(Freedom of Information and Protection of Privacy Act / Municipal Freedom of Information and Protection of Privacy Act)

This information is collected under the legal authority of the *Ontario Disability Support Program Act,* 1997, sections 5, 10, 45 & 46 or the *Ontario Works Act,* 1997, sections 7, 8, 15 57 & 58 for the purpose of administering Government of Ontario social assistance programs. For more information, please contact your caseworker at your local Ontario Works office. For local office contact information, please contact ServiceOntario toll-free at 1-888-789-4199 (TTY: 1-800-387-5559) or visit the ministry's website at www.ontario.ca/mcss.