

IN THE \_\_\_\_\_ COURT FOR \_\_\_\_\_ COUNTY

STATE OF TENNESSEE

vs.

Case/Docket No. \_\_\_\_\_

or

Warrant No. \_\_\_\_\_

Defendant

DOB: \_\_\_\_\_

**UNIFORM AFFIDAVIT OF INDIGENCY**  
**FOR PURPOSES OF DUI MONITORING FUND (T.C.A. § 55-10-419)**

Comes the defendant and, subject to the penalty of perjury, makes oath to the following facts (please list, circle, complete, etc.):

1. Full name: \_\_\_\_\_  
List any other names you have used: \_\_\_\_\_
2. Birthdate: \_\_\_\_\_
3. Address: \_\_\_\_\_
4. Telephone Nos.: (Home/Cell) \_\_\_\_\_ (Work) \_\_\_\_\_
5. Are you working? ( ) Yes ( ) No If yes, where? \_\_\_\_\_
6. How much money do you make? \$ \_\_\_\_\_ per hour/day/week/month/year (circle one)
7. Do you have any income other than the income listed above? ( ) Yes ( ) No  
If yes, list the total amount. \$ \_\_\_\_\_  
Remember, possible sources include, but are not limited to the following: interest, gifts, AFDC, SSI, social security, retirement, disability, pension, unemployment, alimony, and workers' compensation.
8. Your total annual income after taxes is \$ \_\_\_\_\_
9. Number of persons in your family/household: \_\_\_\_\_
10. Acknowledging that I am still under oath, I certify that I have listed above all income I receive.
11. By signing this form, I agree to file a copy of my most recent income tax return if requested by the court.
12. I understand that, pursuant to the perjury offense set out in T.C.A. § 39-16-702, it is a Class A misdemeanor for which I can be sentenced to jail for up to 11 months, 29 days or be fined up to \$2,500, or both, if I intentionally misrepresent, falsify or withhold any information required in this affidavit. I also understand that I may be required by the Court to produce other information in support of my request to be declared indigent for purposes of using the DUI monitoring fund.

This \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

Signature of Defendant

Sworn to and Subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
Signature of Judge/Clerk

## Order Regarding Indigency Determination for Purposes of Payment by the DUI Monitoring Fund

\_\_\_\_ I hereby find that the above-named defendant is NOT indigent and does not qualify for financial assistance to pay costs associated with a functioning ignition interlock device, transdermal monitoring device, or alternative alcohol or drug monitoring device.

OR

\_\_\_\_ I hereby find that the above-named defendant receives an annual income, after taxes, of 185% or less of the poverty guidelines updated periodically in the federal register by the United States Department of Health and Human Services under the authority of 42 U.S.C. § 9902(2), and that the defendant is therefore indigent and, subject to availability of funds, qualifies for financial assistance to pay costs associated with a functioning ignition interlock device, transdermal monitoring device, or alternative alcohol or drug monitoring device.

***If defendant is declared indigent, complete the next sections:***

1.

\_\_\_\_ Defendant is found to have the ability to pay a portion of the costs associated with the required device, and is ordered to pay \$\_\_\_\_\_, pursuant to T.C.A. §55-10-419(b).

\_\_\_\_ Costs associated with the required device in the amount of \$\_\_\_\_\_, (not to exceed \$200/month, per device) will be reimbursed to the provider by the DUI monitoring fund.

The total cost of the required device is \$\_\_\_\_\_.

2. Length of time the defendant is ordered to use/wear the device: \_\_\_\_\_

3. Number of devices the defendant is ordered to use/wear: \_\_\_\_\_

4. Type of device(s) ordered:

\_\_\_\_ Ignition interlock device

\_\_\_\_ Transdermal monitoring device

\_\_\_\_ Other alternative alcohol or drug monitoring device (List type of device: \_\_\_\_\_  
\_\_\_\_\_)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Judge

**\*\*\*\*\* The defendant must submit a copy of this form to the device provider before installation of the ignition interlock device, transdermal monitoring device, or alternative alcohol or drug monitoring device; and the device provider must submit a copy of this form to the state treasurer prior to being reimbursed, along with a copy of the signed court order indicating that the use of the device(s) has been ordered by the Court. Pursuant to T.C.A. § 55-10-419(a)(1)(C), no more than two hundred dollars (\$200.00) per month shall be expended from the fund to pay the costs associated with the device.**

# United States Department of Health and Human Services

## 2018 Poverty Guidelines

<u>Persons in Family/Household</u>	<u>Poverty Guideline</u>	<u>185%</u>
1	\$12,140	\$22,459
2	\$16,460	\$30,451
3	\$20,780	\$38,443
4	\$25,100	\$46,435
5	\$29,420	\$54,427
6	\$33,740	\$62,419
7	\$38,060	\$70,411
8	\$42,380	\$78,403

For families/households with more than 8 persons, add \$4,320 for each additional person.