IN THE _____ COURT FOR _____ COUNTY

STATE OF TENNESSEE

vs. **Case/Docket No. _____**
or
_____ **Warrant No. _____**

Defendant
DOB: _____

UNIFORM AFFIDAVIT OF INDIGENCY FOR PURPOSES OF ELECTRONIC MONITORING INDIGENCY 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. Address: _____

3. Telephone Nos.: (Home/Cell) _____ (Work) _____

4. Are you working? ( ) Yes ( ) No If yes, where? _____

5. How much money do you make? $ _____ per hour/day/week/month/year (circle one)

6. 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.

7. Your total annual income after taxes is $_____

8. Number of persons in your family/household: _____

9. Acknowledging that I am still under oath, I certify that I have listed above all income I receive.

10. By signing this form, I agree to file a copy of my most recent income tax return if requested by the court.

11. 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 electronic monitoring indigency fund.

    This _____ day of _____, _____. _____.
    Signature of Defendant

    Sworn to and Subscribed before me this _____ day of _____, _____.

    _____
    Signature of Judge/Clerk

Rev. 07/18
Authority: T.C.A. § 55-10-419(e)

Order Regarding Indigency Determination for Purposes of Payment by the Electronic Monitoring Indigency 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 electronic monitoring indigency 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.***

Rev. 07/18
Authority: T.C.A. § 55-10-419

United States Department of Health and Human Services

2018 Poverty Guidelines

Persons in Family/Household	Poverty Guideline	185%
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.

Source: U.S. Department of Health & Human Services
Poverty Guidelines for the 48 Contiguous States and the District of Columbia
Rev. 1/13/18