

Patient Name: _____	
MRN: _____	CSN: _____
D.O.B: _____	Admit Date: _____



RYAN WHITE PROGRAM

Six Month Self-Attestation of Eligibility Changes

THMP eligibility requires an update to your eligibility every six months. Please answer all questions below and provide any required documents for changes in your income, insurance status, or residency. THMP will require this information by the date listed on the enclosed letter.

Name:	Phone Number:
Social Security Number:	Date of Birth:
<p><u>Address</u> ▶ <u>(please provide your current address)</u></p>	
<p><i>If you have moved, please include a copy of your driver's license with your new address, utility bill, rental agreement, or other documentation of your new address</i></p>	
<p><u>Income (Includes income of legal or common law spouse if married)</u></p>	
<input type="checkbox"/> I/We have no income <input type="checkbox"/> My/Our income has not changed <input type="checkbox"/> My/Our income has changed	<p><i>If your income has changed since your last recertification, please include appropriate documentation of a tax return transcript, two consecutive paystubs, Social Security award letter, or if no income, Supporter Statement (if attestation is for THMP, please submit the THMP Supporter Statement).</i></p>
<p><u>Insurance Status</u></p>	
<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Medicare Part D	<input type="checkbox"/> ACA health plan <input type="checkbox"/> Private Insurance <input type="checkbox"/> No Form of Insurance
<p><i>If you have insurance coverage of any kind, please include front and back copies of your insurance cards.</i></p>	
<p>Client <u>or</u> Staff Signature: _____</p>	
<p>Date: _____</p>	
<p><i>I attest that my signature on this form indicates the information provided is accurate and complete to the best of my knowledge.</i></p>	
<p>***In person attestations must be signed by the client. Phone attestations must include the name, signature, and agency name of the staff member completing the form.***</p>	
Staff Name:	Agency/Program:
Phone #:	Fax #:
_____	_____
_____	_____