Patient Name:_____

MRN:_____ CSN:_____

D.O.B:_____ Admit Date:_____

University Health

RYAN WHITE PROGRAM

STATEMENT OF NO INCOME

_____ _____

CLIENT NAME **CLIENT NUMBER**

INSTRUCTIONS: All members (age 18 and older) of a household applying for Ryan White Program services are required to verify all income received. If any member of the household, including the head of household, claims no income, he/she must read the following statement and complete the form below with all necessary information and signature(s).

The undersigned individual(s) certify that:
I have received no income during the time period indicated:

Head of household claiming no income from _____ To _____

Signature _____ Date _____

Social Security No. _____

Other household member claiming no income from _____ To _____

_____ _____

Signature Date

_____ _____

Printed Name Social Security No.

Other household member claiming no income from _____ To _____

_____ _____

Signature Date

_____ _____

Printed Name Social Security No.

Other household member claiming no income from _____ To _____

_____ _____

Signature Date

_____ _____

Printed Name Social Security No.