Recertification Self Attestation Form

AIDS Drug Assistance Program (ADAP) and Health Insurance Assistance Program

Continued Ryan White 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. Sign and date and return this entire form with any required documents within 14 business days to ensure continued access to Ryan White services. We will notify you if there have been any changes in your eligibility. Please direct any questions to (202) 671-4815.

Name: **Date:**

Social Security Number: **Date of Birth:**

ADDRESS CHANGE

❒ Yes ▸ ▸ ▸ ▸ ▸

❒ No

New Address

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

INCOME (Includes income of legal or common law spouse if married)

❒ I have no income

❒ My income has not changed

❒ My income has changed

If your income has changed since your last recertification, please include appropriate documentation of a tax transcript, two consecutive paystubs, Social Security letter, or support statement.

INSURANCE STATUS

❒ Medicaid/Alliance

❒ Medicare

❒ Medicare Part D

❒ ACA health plan

❒ Private Insurance

❒ No Form of Insurance

If you have insurance coverage of any kind, please include front and back copies of your insurance cards.

CERTIFICATION STATEMENTS

Alternate Contact: I authorize DC ADAP to speak with the following person or persons (i.e. social worker, case manager, family member) about my application if you are not able to contact me. If at any time I wish to revoke this person's authorization, I will notify ADAP at (202) 671-4815.

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Name **Phone Number** **Relationship**

I certify that all of the information provided above is accurate and true. I authorize my healthcare provider to allow DC ADAP to access (1) my healthcare records and other documents related to services rendered and (2) other pertinent medical information to the program for the purpose of determining my medical eligibility for programs and evaluation. Information may be shared between District agencies such as Medicaid and the HIV/AIDS Administration in order to determine and process my eligibility for various programs. Further, I agree to inform DC ADAP of any changes in my residency/address, income, Medicaid eligibility status and insurance coverage. If I deliberately misrepresent information on my application, I may be required to repay benefits received under DC ADAP, and I may be prosecuted under applicable District and Federal law.

Applicant's Signature ________________________________ **Date** ________________