<u>APPENDIX 7</u>

Ryan White HIV/AIDS Program

6 MONTH SELF-ATTESTATION STATEMENT

NAME: ____
FIRST MIDDLE LAST

Has there been a change in your change in your medical insurance, income, household size or address in the past 6 months?

☐ NO – There has been no change in my medical insurance, income, household size or address

In the future, should there be a change with any of the aforementioned criteria, I understand that I must notify the program immediately. **If your answer is no, you have completed this form. Please sign at the bottom.**

☐ YES – There has been a change in one or more of the following:

☐ Medical Insurance

My new insurance information is listed below:

Insurance company: ______________________________

Policy #: ____

<u>A copy (both front and back) of my insurance card is attached to this form</u>

☐ Income Change

I have experienced a change in household income. My new household income is $______________ per month. **Please provide proof of this income**

☐ Household Size Change

There are now ____ persons in my household, including ___ persons under the age of 18, as of ______________

☐ Address change

I have moved. My new address is: __________________________________

City: ______________________________ State:______ ZIP: _________

Phone: (_____) _______________________________________

Please provide proof of this address.

I understand I will be notified if any changes affect my eligibility for the cap on charges or sliding fee discount.

____ ____________________________
Patient Signature Date

____
Witness (if patient is unable to sign)