# Annual Self-Attestation of Eligibility Changes

Ryan White Part B eligibility requires an update every twelve months. Clients may be recertified by the end of the calendar month in which their recertification is required.

Proof for income and for residence must be in the client chart; and, be verified independently at least once every 24 months. Self-attestation proofs can be used to reduce barriers to services, but should not be used two years in a row.

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name:** |  | | | | | | | **Phone:** |  | |
|  | | | |  **I do not have a SSN** | | |  | |  | |
| **Social Security Number:** | | | |  | | | **Date of Birth:** | |  | |
| **Address►**  **(please provide your current 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/We have no income   My/Our income has not changed   My/Our income has changed | | | | | *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, the Certification of No Income form.* | | | | | |
| **Insurance Status** | | | | | | | | | | |
|  Medicaid   Medicare   Medicare Part D | | | | | |  ACA health plan   Private Insurance   No Insurance | | | | |
| **Client *or* Staff Signature:** | |  | | | | | | **Date:** |  |  |
| *I attest that my signature on this form indicates the information provided is accurate and complete to the best of my knowledge.*  **\*\*\*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. \*\*\***  **Staff Name: Agency/Program: Phone #: Fax #:**    **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | |