



**APPENDIX 7**  
**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 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 #: \_\_\_\_\_

A copy (both front and back) of my insurance card is attached to this form:

**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.

Did you relapse in the last 6 months \_\_\_ Yes or \_\_\_ No? or Any Trauma? \_\_\_ Yes or \_\_\_ No

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

Witness (if patient is unable to sign) \_\_\_\_\_