**Six Month Self-Attestation of Eligibility Changes**

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 45 days to ensure continued access to Ryan White services, **including the THMP program (provides your medications)**, if applicable. You will be notified if there have been any changes in your eligibility.

**Please direct any questions to your provider agency or if you have any questions specific to the THMP call 1-800-255-1090. Please note that your Ryan White Provider is not the same as the THMP.**

Please note that program eligibility will be independently verified and any inaccuracies in information provided will be shared between DSHS and the service provider.

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name:** |  | | | | | | | | **Phone Number:** |  | |
| **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, Supporter Statement (if attestation is for THMP, please submit the THMP Supporter Statement).* | | | | | |
| **Insurance Status** | | | | | | | | | | | |
|  Medicaid   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.* | | | | |
| **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 #:** | | | | | | | | | | | |