



DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH
HIV/AIDS, HEPATITIS, STD, TB ADMINISTRATION



Recertification Self Attestation Form
AIDS Drug Assistance Program (ADAP)
Health Insurance Assistance Program

899 North Capitol Street, NE
Washington, DC 20002
Phone: (202) 671-4900
Fax: (202) 673-4365

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) 671-4900.

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 [ ] ACA health plan
[ ] Medicare [ ] Private Insurance
[ ] Medicare Part D [ ] No Form of Insurance
If you have insurance coverage of any kind, please include front and back copies of your insurance cards.

HIV Information (To be Completed by a Physician/Case Manager)

Most recent CD4 count \_\_\_\_\_ Date \_\_\_\_\_
Most recent Viral load \_\_\_\_\_ Date \_\_\_\_\_
Name of Physician: \_\_\_\_\_ DC License Number \_\_\_\_\_
Office Phone: \_\_\_\_\_ Office Fax \_\_\_\_\_
Physician' signature/Case Manager: \_\_\_\_\_ Date: \_\_\_\_\_

I affirm, under the penalties for perjury, that the foregoing and following information is true, accurate, and complete. I understand that payments submitted will be from Federal funds, and that any falsification or concealment of material fact may be prosecuted under Federal and State laws. The District of Columbia Department of Health Aids Drug Administration program may ask for additional information regarding any of the information submitted as part of this form and application. DC ADAP will pursue repayment in all instances of improper or duplicate payment. DC ADAP will recoup all paid increased payments if the applicant is found to be ineligible for this program. By signing this form, the applicant attests that he/she qualifies for the DC ADAP program and that the above is true.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

REPORT FRAUD, WASTE, AND ABUSE: To report fraud, waste, or abuse within the District government, contact the DC Office of the Inspector General's hotline by phone at 1-800-521-1639 (toll free) or 202-724-TIPS (8477), by email at hotline.oig@dc.gov, or by TTY at 711. For additional information, visit the Office of the Inspector General's website at oig.dc.gov.