SELF-ATTESTATION FORM

Client DOB _____**(P)**
ARIES ID # _____**(P)**
Client ID # _____**(P)**

(P) Date: _____

(P) Dear _____,

Your current eligibility is due to expire on _____/_____/_____ (P). You must complete and submit this form to your Eligibility Worker/Enrollment site, by fax or mail, at least seven (7) days before the expiration date listed above. If this form is not received, you may not be able to get services. The Eligibility Worker will determine if this completed form meets eligibility requirements. If any of the information does not meet eligibility requirements, the Eligibility Worker will contact you for an appointment.

(P) = Provider to complete sections (C)=Client to complete sections (EW) = Eligibility Worker to complete

(C) Please complete the information below:		
Your current residential address: (Do not write mailing address)		
Your current medical insurance: (Check all that apply)	☐ I have Medi-Cal (*CalOptima*, DentiCal) ☐ I have Medicare ☐ I have Medi-Medi	☐ I have **NO** medical insurance ☐ I have Private Dental Insurance ☐ I have Private Medical Insurance (i.e. Blue Cross)
(C) Please indicate if the information below is correct by checking the appropriate box:		
(P) Monthly income $ _____	☐ My income has **not** changed **(C) OR** ☐ My income has changed to $ _____ **(C)**	

(P) Referred to apply for ACA ☐ Medi-Cal MAGI or ☐ Buy private medical insurance	☐N/A **(P)**	Client Initials _____**(C)**
(P) ☐ Client was informed of the tax penalties for not having medical insurance	☐N/A **(P)**	Client Initials _____**(C)**
(P) ☐ Open enrollment period is closed for CC client advised about qualifying events	☐N/A **(P)**	Client Initials _____**(C)**
(P) ☐ Client is over 138% FPL and has opted-out of enrolling in private medical insurance	☐N/A **(P)**	Client Initials _____**(C)**

Client Acknowledgment of Understanding

According to Title 18, Section 1001 of the U.S. Code, it is a felony for any person to knowingly and willingly make false or fraudulent statements to any department of the United States Government. I, the undersigned, hereby certify that all statements contained herein, are true and correct to the best of my knowledge and belief. I understand the information I provide in this certification is subject to verification, and I agree to provide necessary documentation if requested to do so.

Client Signature: _____ **Date:** _____ **Contact Number:** _____ ☐**N/A (C)**

(P) Submitted By: _____ **Contact Number:** _____ ☐**N/A (P)**

For Agency Use Only (EW)

Reviewed Residential Address ☐ No Change ☐ Acceptable proof of change received ☐ Requires eligibility appointment
Reviewed Medical Insurance ☐ No Change ☐ Acceptable proof of change received ☐ Requires eligibility appointment
Reviewed Income Information ☐ No Change ☐ Acceptable proof of change received ☐ Requires eligibility appointment

☐ **No Pending Documents OR** ☐ **Pending Documents are due by_____, complete all applicable below.**

☐ Proof of Residential Address ☐ N/A Type: _____ Date Received: _____	☐ Proof of Income ☐ N/A Type: _____ Date Received: _____	☐ Proof of Insurance Status ☐ N/A Type: _____ Date Received: _____

Eligibility data updated in ARIES on _____ at all "Active" Ryan White-funded agencies.

EW Name and Signature: _____ Date Reviewed: _____

Annual Eligibility Expiration Date: _____

Please complete form and fax to: (714) 834-8655 or
Mail to: 17th Street Care P.O. Box 6099, Santa Ana, CA 92706-0099 **Attention:** Eligibility Verification Team

Revised 11/05/14