VERIFICATION OF BENEFITS

Ryan White Part B Program

I, _____, have applied for Direct Emergency Assistance through the Ryan White Part B Program. The United States Government requires verification of insurance or lack thereof.

QUARTERLY

_____ I state during this verification process that I **DO** have insurance at this time*

_____ I state during this verification process that I **DO** receive TANF at this time in the amount of_____

_____ I state during this verification process that I **DO** receive Medicaid at this time.

ANNUALLY

_____ I state during this verification process that I **DO** receive Medicare at this time.

_____ I state during this verification process that I **DO** receive SSI/SSDI at this time in the amount of_____

_____I access Ryan White Part C program

_____I access NE ADAP program

_____I am on a patient assistance program for medications/care

I understand that it is my responsibility to report any change in any of the above within 10 business days after such change.

I verify that all statements regarding my insurance coverage (or lack thereof) are true and that this Verification of Benefits Statement must be verified and completed with my Case Manager every 3 months.

Signature: _____ Date:_____

Applicant

Witness: _____ Date:_____

Case Manager

'BENEFITS VERIFICATION' STATUS MUST BE REVIEWED AT LEAST EVERY 3 MONTHS BY CASE MANAGER AND CLIENT.

*(Current card must be kept on file).

06/2013