

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).