ILLINOIS Department of Public Health
Ryan White Part B Program

Authorization for Release of Health Information

First Name (print)	Middle Initial	Last Name (print)

Social Security Number (Leave blank if no valid SS number for client)	Date of Birth (mm/dd/yyyy)
	/ /

Please read all statements and sign in the space provided to certify that you have read and understand this authorization. All references to "Program" or "Programs" refers to the Illinois Department of Public Health, Ryan White Part B Program, inclusive of any and all federal funding utilized including Housing Opportunities for Persons with AIDS (HOPWA), and/or successor programs in which you participate or to which you apply for services.

1. I certify that the information I provide to the Program is true and accurate to the best of my knowledge. I understand that I may be disqualified from the Program and/or prosecuted for willfully providing false information.
2. I understand that the information requested by the Program is for the purpose of determining my eligibility for a state and federally funded program to which funding is limited and may expire at any time without extended or alternate funds being available.
3. I understand that eligibility approval does not mean I will receive all services offered by the Program. I understand each service may require additional information, and that I must provide this information for verification before provision of said services.
4. If I am enrolled in the Program, I will be granted an eligibility period of no more than six months. Upon the conclusion of my eligibility period, I will be required to reapply and must provide updated eligibility information to continue accessing services. I agree to submit periodic information regarding my continued eligibility for participation in the program(s), including proof of income, proof of residency, availability of health insurance coverage, and an updated and signed version of this form with my Recertification Application every (6 months) as per Federal Guidelines.
5. I agree to notify, or to have my Case Manager (if applicable) notify the Program of any change in circumstances affecting my participation in, or eligibility for, the Program within thirty (30) days of the change. This includes any changes in income, address or insurance coverage. I understand changes in my situation will be periodically evaluated to determine continued eligibility for the Program.
6. I understand that all mailed correspondence sent by the Program will be sent to the address I have on file with the program only if I have consented to receive mail.
7. I authorize the Program to release my enrollment, eligibility, service utilization, and any other information necessary to facilitate my enrollment in the program and the provision of services to my physicians on file, program service providers, treatment centers, pharmacy benefit managers, third party administrators, health insurers, and\or other entities that are under contract with the program with the understanding that my status will never be disclosed to entities not affiliated with the Ryan White Part B Program in the bullet point list below.
8. If I experience discrimination because of the release or disclosure of medical related information, I may contact the Illinois Department of Human Rights at (217) 785-5100 or (312) 814-6200. This agency is responsible for enforcing the Illinois Human Rights Act which provides certain protections for persons with disabilities.
9. I acknowledge that my health insurance premiums (if applicable) are being paid by the Program via a contractual third party payer source. In consideration of same, I hereby authorize and direct my health insurer to directly reimburse the Program for any unused premium payments should my insurance policy terminate or be cancelled for any reason, including but not limited to future ineligibility, death, voluntary termination, involuntary cancellation, or termination by operation of law.
10. I agree to indemnify and hold the Illinois Department of Public Health (IDPH) harmless from any and all claims for making premium reimbursement payments directly to the IDPH or any entity under contract with the IDPH in connection with Program Services. I agree to indemnify and hold the IDPH, or any entity under contract with the IDPH in connection with Program Services, harmless from any and all claims for receiving premium reimbursement payments directly from IDPH or my health insurer. This agreement shall be binding on my administrators, executors, heirs, successors and assigns and shall remain in full force and effect during the time period in which I am enrolled in the Program(s).
11. I agree to reimburse IDPH for any and all premium reimbursement payments that are paid to me in error during my enrollment.
12. I understand that my records are protected under the Health Insurance Portability and Accountability Act, Pub.L 104-491, 110 Stat. 1936, enacted August 21, 1996, and Illinois Statute 410 ILCS 305 relating to confidentiality of medical information, and cannot be disclosed to any other entity except those referenced herein without my written consent. I do not have to consent to the release of this information. However, if I refuse to sign this authorization, I will be ineligible to receive services through this Program.
13. I understand that I may revoke this authorization at any time in writing. However, the release shall remain valid for a period of **24 months** from the date this form is signed, or until such time as I inform the administrator of the Program(s), in writing, of my wish to terminate services in the Program(s). I also understand that I will still be required to sign a new authorization form every 6 months to continue Ryan White Services. I also understand that each time I sign a new reauthorize on a 6 month basis for renewal purposes that any and all previous authorization(s) become null and void.

ALTERATION OF THIS DOCUMENT IS CONSIDERED FRAUDULENT, AND IS PROHIBITED

14. I authorize the Program to release information related to my enrollment, eligibility, service utilization, and any other information the program determines necessary to facilitate my enrollment into the program and the provision of services to the following entities:

    a. Case Management providers funded by the Program. This includes but is not limited to both medical and non-medical case management providers, medical benefit coordinators/benefit specialists, client representatives, and peer navigators.

    b. Certified Application Counselors (CAC) licensed under the authority of the Program.

    c. Members of my medical care team including, but not limited to, the physicians, physician assistants, nurses, nurse practitioners, mental health providers, substance abuse providers, oral health care providers, and any professional staff working under their authority.

    d. Entities with a grant or contractual relationship with the Program, including the grantee or contractor's sub-recipients/sub-contractors in contractual relationships to carry out activities covered by the Program. This includes the Program's regional lead agencies, contracted community-based organizations, contracted dispensing pharmacy, and contracted third party payer for insurance premiums and client out of pocket medical costs.

    e. Individuals or entities listed on my eligibility assessment as assisting me with my enrollment and eligibility.

    f. IL Department of Insurance (insurance coordination), Employment Security (income verification), Health and Family Services (Medicaid verification), the Centers for Medicare & Medicaid Services and other program/sections within the IL Department of Public Health per Illinois Statute 410 ILCS 305.

    g. Any grantee or subrecipient of any part of the Ryan White Care Act for the purposes of service coordination and to prevent duplication of information and services.

    h. Entities employed or authorized by the IL Department of Public Health to conduct reengagement and outreach activities in instances when I may have a break in my enrollment to ensure I have not fallen out of medical care. These activities will take place during the 24 months covered by this authorization.

With my signature, I authorize the Program and the entities identified in item 14 of this document to share my information with the additional entities listed below and I understand that I must list these contacts on each submission of this form in order to allow the Program to continue to share my information with them.

_____
Individual Name

(_____) _____ - _____ Is this individual aware of your status? ☐ Yes ☑ No
Telephone

_____
Individual Name

(_____) _____ - _____ Is this individual aware of your status? ☐ Yes ☑ No
Telephone

Client Signature (age 12 and older) **Date**

Parent/Guardian (if under 12) or Legal Representative **Date**

ALTERATION OF THIS DOCUMENT IS CONSIDERED FRAUDULENT, AND IS PROHIBITED

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY**.

THIS NOTICE GIVES YOU INFORMATION REQUIRED BY LAW about the duties and privacy practices of the Illinois Department of Public Health's (IDPH) Ryan White Part B Program to protect the privacy of your personal health information.

When IDPH provides you with pharmaceutical and/or premium assistance, medical case management, mental or physical health, dental, or social services, IDPH receives and maintains personal health information about you. IDPH may also receive and maintain financial and billing information about you. To help IDPH provide these comprehensive core and supportive care services to you, IDPH may contract with companies, social service agencies, or individuals. These contractors may also receive and maintain your personal information. IDPH will use and share only the minimum necessary health information that our staff and contractors need to do their jobs. IDPH and its contractors are required by law to (1) maintain the privacy of protected health information; (2) to provide you with notice of IDPH's legal duties and privacy practices with respect to your protected health information; and (3) to notify affected individuals of a breach of unsecured protected health information.

This Notice describes how IDPH may use and disclose your information. It also describes your rights and IDPH's legal obligations with respect to your information. IDPH is required to follow the terms of this Notice until the Notice is replaced. IDPH reserves the right to change the terms of this Notice at any time. If IDPH makes changes to this Notice, the new Notice will be available in IDPH offices, upon request, and on our website: https://dph.illinois.gov. Any changes to our practices will apply to all of your personal health information maintained by IDPH.

How IDPH May Use and Disclose Your Health Information

IDPH may share your information without your authorization in the following ways:

Treatment: IDPH can use your health information and share it with other professionals who are treating you in order to enhance coordination of comprehensive care services. For example: IDPH may disclose your personal health information to your doctor, at the doctor's request, for treatment by your doctor.

Payment: IDPH can use and share your information for payment purposes. For example: IDPH may use or disclose your personal health information to provide eligibility information to your doctor when you receive treatment; to pay for claims for covered health care services; to pay for insurance premiums if eligible; to assist with payment of approved medical/pharmaceutical out-of-pocket costs; or to recover costs from other medical insurance or probate estates.

Health Care Operations: IDPH can use and share your health information for IDPH operations, to improve your care, and to contact you when necessary. For example: IDPH or its contractors may use or disclose your personal health information (1) to conduct quality assessment and improvement activities; (2) to review applications for services; (3) to engage in care coordination or case management; (4) to manage, plan or develop IDPH's services and budget; (5) to coordinate services with another public benefit program; (6) to create or provide individualized service or treatment plans; or (7) to cooperate with State and federal auditors.

Health Services: IDPH or its contractors may contact you to remind you of appointments or to give you information about treatment alternatives or other health-related benefits and services that may be helpful to you or your family.

IDPH is allowed, and in some instances required, to share your information in other ways such as for public health and research. IDPH must meet conditions in the law before it can share your information for these purposes.

Public Health and Safety Issues: IDPH can share health information about you with public health authorities for public health activities such as: preventing or controlling disease, injury, or disability; keeping vital records; avoiding a serious threat to the health or safety of a person or the public; and reporting suspected abuse, neglect, or domestic violence to governmental or social services agencies. IDPH also can share your health information with a governmental agency authorized to oversee government health care programs.

Research: IDPH can use or share your information for health research in limited circumstances where the information will be protected by the researchers.

As Required by Law: IDPH will share information about you if State or federal laws require it, including with the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) for a compliance review or complaint investigation or with a personal representative appointed by you or designated by law.

Lawsuits and Legal Actions: IDPH can share health information about you in response to a court or administrative order, or in response to a subpoena.

Public Health Activities and Public Health Reporting: IDPH is permitted to disclose protected health information for public health activities (such as surveillance and investigation), interventions and activities related to public health oversight; and to coordinate care and treatment with other IDPH Health Protection Entity's (e.g., Sexually Transmitted Disease Office) activities.

Other Agencies: IDPH can share your information with another agency administering a government program providing public benefits, with respect to eligibility or enrollment information, and to better coordinate, administer and manage government programs and for treatment and care coordination of the Department's program.

IDPH follows the HIPAA guidelines. IDPH also follows any federal or State law that gives greater privacy protections than HIPAA. For example, IDPH follows the Illinois Mental Health and Developmental Disabilities Confidentiality Act concerning mental health records, 740 ILCS 110; the Illinois Personal Information Protection Act which protects "personal information" that is not otherwise lawfully made available to the general public from federal, State, or local government records, 815 ILCS 530; the federal Confidentiality of Alcohol and Drug Abuse Patient Records Act concerning the disclosure of drug or alcohol information, 42 U.S.C §290dd-2; 42 CFR Part 2; and the federal Family Educational Rights and Privacy Act concerning the privacy of education records, 20 U.S.C. §1232g; 34 CFR Part 99; 34 CFR Part 99

Our Responsibilities:

IDPH is required by law to maintain the privacy and security of your protected health information. IDPH will notify you as required by law when there is a breach of your unsecured protected health information. In some circumstances IDPH's business associate may provide the notification to you.

IDPH must follow the duties and privacy practices described in this Notice and give you a copy of it.

IDPH will not use or share your information for any purposes not described in this Notice without your written permission. If you do authorize IDPH to use or disclose your health information, in most cases, you may revoke your written authorization at any time. Your revocation will be effective from the date IDPH receives the revocation. (Authorization and Revocation forms are available on IDPH's Ryan White Part B website.)

IDPH is required to obtain your authorization prior to using or disclosing psychotherapy notes, except under the limited treatment, payment, and health care exceptions of 45 CFR § 164.508(a)(2).

IDPH does not market or sell your protected health information. However, IDPH would be required to obtain your authorization prior to selling any of your protected health information or disclosing any of your protected health information for marketing purposes.

Your Rights:

Communicate Confidentially: You can ask in writing that IDPH communicate with you by a reasonable alternative means or at a reasonable alternative location. For example, you may request that IDPH communicate with you by e-mail rather than by telephone, through a translator, or at home instead of your place of work. IDPH will agree to all reasonable requests.

Request a Copy of this Privacy Notice: You are entitled to a paper copy of this Notice at any time, even if you have agreed to receive the Notice electronically. An electronic version of this Notice of Privacy Practices is also available on the IDPH website: www.idph.state.il.us

Inspect and Amend Protected Health Info: You are entitled to inspect and copy your protected health information at any time. At the time of inspection you may request an amendment to your information. IDPH reserves the right to deny your request for amendment.

Choose Someone to Act on Your Behalf: You may give someone a medical power of attorney, or a legal guardian may be appointed for you to exercise your rights and make choices about your health. Before IDPH takes any action, IDPH will confirm the person has this authority and can act on your behalf.

Right to Accounting of Disclosures: You are entitled to receive an accounting of disclosures of protected health information as provided by 45 C.F.R. 164.528.

File a Complaint: If you believe your privacy rights have been violated by IDPH, you have the right to complain to IDPH or to the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with the IDPH Chief Privacy Officer, within 180 days of the suspected violation, at the address where you receive services listed below or you may file a complaint with the United States Department of Health and Human Services, Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201; or calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. IDPH will not retaliate against you for filing a complaint with either IDPH or with the U.S. Department of Health and Human Services.

Your Choices: You have the right to request that IDPH restrict the uses or disclosures of your protected health information to carry out treatment, payment, for health care operations. Your requests must be clearly expressed. IDPH is not required to agree to your requests.

IDPH does not engage in fundraising. However, you may opt out of receiving any fundraising communication from IDPH.

Privacy Officer

To request additional copies of this notice or to receive more information about IDPH's privacy practices or your rights, please contact the Chief Privacy Officer at the following address:

Kyle Stone
Illinois Department of Public Health
535 West Jefferson Street, Fifth Floor
Springfield, IL 62761
Telephone – 217-557-2556

ACKNOWLEDGMENT OF RECEIPT

Client First Name	Middle Initial	Client Last Name

Social Security Number (Leave blank if no valid SS number for client)	Date of Birth (mm/dd/yyyy)

Please have the client/patient complete this acknowledgment of receipt of the Notice of Privacy Practices. Give customer a copy of this Notice and put the original in the medical or clinical record.

I hereby acknowledge that I have received a copy of the IDPH Notice of Privacy Practices. I also recognize that I will be required to submit a completed Privacy Practice signature page at each 6 month eligibility determination.

Client Signature (age 12 and older) **Date**

or

Parent of Minor (clients age 11 and younger) **Date**

or

Legal Guardian **Date**

ACUSE DE RECIBO

El nombre del cliente	La inicia media	El apellido del cliente

Número de Seguridad social (Permiso en blanco si no aplicable)	Fecha de Nacimiento (mm/dd/yyyy)

Por favor haga que el cliente / paciente complete este acuse de recibo del aviso de privacidad. Dar al cliente una copia de este aviso y poner el original en el expediente médico o clínico.

Por la presente reconozco que he recibido una copia del Aviso de prácticas de privacidad IDPH . También reconozco que se me exigirá que presente una hoja de firma prácticas de privacidad completado en cada determinación de elegibilidad de 6 meses.

Firma del cliente (12 años o más) **Fecha**

o

Firma de padre/madre del menor (11 años de edad o menos) **Fecha**

o

Firma del tutor legal **Fecha**

ILLINOIS Department of Public Health

Ryan White Part B Program

HOUSEHOLD INCOME STATEMENT

Client First Name	Middle Initial	Client Last Name

Social Security Number (Leave blank if no valid SS number for client)	Date of Birth (mm/dd/yyyy)

Separate section must be filled out for each legal household member age 18 and over – even if they do not earn income

All sources in **BOLD and with an asterisk that have an amount or are answered with a YES require additional supporting documentation**

Client		Additional Legal Household Member over age 18	
		Name:	
CURRENT MONTHLY INCOME (cannot leave blank)		**CURRENT MONTHLY INCOME (cannot leave blank)**	
Wages, salaries, cash, tips	*	**Wages, salaries, cash, tips, etc.**	*
Do you receive pay stubs (yes/no)?	*	**Do you receive pay stubs (yes/no)?**	*
Alimony or spousal support received	*	**Alimony or spousal support received**	*
Self-employed, business income or loss		Self-employed, business income or loss	
IRA Distributions		IRA Distributions	
Pensions and annuities (veteran or employer based pensions, retirement or disabilities)	*	**Pensions and annuities (veteran or employer based pensions, retirement or disabilities)**	*
Rental, real estate, partnerships, S Corporations, trusts		Rental, real estate, partnerships, S Corporations, trusts	
Farm income or loss		Farm income or loss	
Unemployment Income	*	**Unemployment Income**	*
Retirement from Social Security (SSA)	*	**Retirement from Social Security (SSA)**	*
Disability from Social Security (SSDI)	*	**Disability from Social Security (SSDI)**	*
Supplemental Income from Social Security (SSI)		Supplemental Income from Social Security (SSI)	
Other income (jury duty, gambling, etc.)	*	**Other income (jury duty, gambling, etc.)**	*
Child Support, workers compensation		Child Support, workers compensation	
Did you file a tax return (yes/no)?		**Did this person file a tax return separately (yes/no)?**	

Comments (Additional room for comments on back):

Client Signature **Date**

ILLINOIS Department of Public Health

Ryan White Part B Program

HOUSEHOLD INCOME STATEMENT

This page is only required if there are more than one additional legal household member over age 18.

Additional Legal Household Member over age 18		**Additional Legal Household Member over age 18**	
Name:		**Name:**	
CURRENT MONTHLY INCOME (cannot leave blank)		**CURRENT MONTHLY INCOME (cannot leave blank)**	
Wages, salaries, cash, tips	*	**Wages, salaries, cash, tips, etc.**	*
Do you receive pay stubs (yes/no)?	*	**Do you receive pay stubs (yes/no)?**	*
Alimony or spousal support received	*	**Alimony or spousal support received**	*
Self-employed, business income or loss		Self-employed, business income or loss	
IRA Distributions		IRA Distributions	
Pensions and annuities (veteran or employer based pensions, retirement or disabilities)	*	**Pensions and annuities (veteran or employer based pensions, retirement or disabilities)**	*
Rental, real estate, partnerships, S Corporations, trusts		Rental, real estate, partnerships, S Corporations, trusts	
Farm income or loss		Farm income or loss	
Unemployment Income	*	**Unemployment Income**	*
Retirement from Social Security (SSA)	*	**Retirement from Social Security (SSA)**	*
Disability from Social Security (SSDI)	*	**Disability from Social Security (SSDI)**	*
Supplemental Income from Social Security (SSI)		Supplemental Income from Social Security (SSI)	
Other income (jury duty, gambling, etc.)	*	**Other income (jury duty, gambling, etc.)**	*
Child Support, workers compensation		Child Support, workers compensation	
Did you file a tax return (yes/no)?		**Did this person file a tax return separately (yes/no)?**	

Comments (Additional room for comments on back):

Client Signature **Date**

ILLINOIS Department of Public Health

Ryan White Part B Program

Verification of Residency Affidavit

Client First Name	Middle Initial	Client Last Name	
Social Security Number (Leave blank if no valid SS number for client)			**Date of Birth (mm/dd/yyyy)**
Street Address			**Apt/Lot/Suite**
City		**State**	**Zip**
		Illinois	

By signing this affidavit, I certify that the residence listed above is my primary residence. I understand that this form must be signed and dated by a third party who cannot be a member of my household or someone who would benefit from my receipt of services.

Client Signature (age 12 and older) **Date**

By signing this form, the third party below is making a legal attestation that the address above is the current residence of the client listed on this form.

Printed Name of Third Party (case manager, shelter staff, etc.)

Signature of Third Party (case manager, shelter staff, etc.) **Date**

ILLINOIS Department of Public Health

Ryan White Part B Program

STATEMENT OF UNDERSTANDING TAX LIABILITY OR REFUND

First Name	Middle Initial	Last Name

Social Security Number (Leave blank if no valid SS number for client)	Date of Birth (mm/dd/yyyy)

With the implementation of the Affordable Care Act, program participants have increased access to some form of insurance coverage. The Affordable Care Act requires enrollees to accurately estimate their income, as well as report any income changes throughout the year to ensure accurate subsidies are provided. Failure to do so will result in additional refunds or penalties being applied to the following year's taxes.

Since the program paid your health insurance premiums during this time, **ALL** refunds associated with overpayment of premiums during this time ***are required to be returned*** to the program! Failure to do so could impact your future enrollments. These refund amounts can be found on line 65 of the IRS Form 1040NR, line 69 of the IRS Form 1040, or line 45 of the IRS Form 1040A.

Similarly, the Program has been granted approval to assist those clients with any penalties associated with excess premium tax credits received as a result of underestimating your income. This only lasts as long as funds are available. These penalty amounts can be found on line 46 of the IRS Form 1040, line 29 of the IRS Form 1040A, or line 44 of the IRS Form 1040NR.

This statement of understanding is required to be completed for all clients who received a refund or a tax health liability associated with an error in income reporting.

Initial each statement, then sign and date the document.

_____ 1) I understand that as a result of my error in accurately reporting and/or updating my income amounts to the Marketplace – resulted in Tax return changes that must be addressed.

_____ 2) I understand that any refunds associated with overpayment are **required** to be returned to the Department immediately, or my enrollment may be impacted.

_____ 3) I understand that the program is able to assist with tax penalties associated with excess premium tax credits that have been assessed as funding allows.

_____ 4) I understand that any payment assistance provided to me by the program for tax penalties is required to be paid directly to the IRS, and that the processing of that payment could potentially be closer to the end of the calendar year.

_____ 5) I understand that the program is only able to assist with the amount of excess advance premium tax credit that in addition to the currently monthly amount we pay for premiums up to and not to exceed $750/month.

_____ 6) I understand that any future tax year's health liabilities as a result of excess advance premium tax credit may not be covered for assistance by the program.

_____ 7) I understand the importance of reporting any income changes throughout the year directly to the Marketplace.

By signing below, I agree to and understand the facts and conditions contained herein.

_____

Signature of Program Participant **Date**

ILLINOIS Department of Public Health

Ryan White Part B Program

AFFIDAVIT OF NO INSURANCE COVERAGE

Client First Name	Middle Initial	Client Last Name

Social Security Number (Leave blank if no valid SS number for client)	Date of Birth (mm/dd/yyyy)

The Ryan White Part B Program is required to ensure that the program is the "Payer of Last Resort" for all services it provides. The implementation of the Affordable Care Act has increased access to some form of insurance coverage for all individuals. To ensure compliance with the federal payer of last resort requirements, all program participants that are eligible for insurance coverage through the areas identified below are **required** to enroll in said coverage when available.

There are a variety of options that program participants may qualify for. These options include traditional Medicaid, expanded Medicaid/Managed Care Plans, Medicare, and private insurance including employer based plans, Illinois Insurance Marketplace plans, and private insurance plans outside the marketplace.

If you have any questions, please contact your case manager or local Lead Agent to find the Medical Benefits Coordinator in your area (see back of document for contact listing).

By signing this affidavit, I acknowledge and understand the statements below and agree to comply with any requirement identified herein.

- I understand that I am required to enroll in health coverage through one of the ways listed above, to satisfy federal payer of last resort requirements.
- I understand that failure to meet this requirement could jeopardize my future enrollments due to cost saving requirements.
- I understand that the Illinois Ryan White Part B Program can assist me with the costs of my premiums for any insurance plan that qualifies for this service (see back side of document). If my insurance plan does not meet these requirements, I will be unable to receive this service from the program.
- I understand that if I am categorically ineligible for coverage through the Illinois Insurance Marketplace or exempt under the Affordable Care Act (eligible for Veterans Benefits or a person of American Indian heritage), I still have insurance coverage options available to me and that these options are outlined above.
- I understand that if I am eligible for Medicare coverage but am not enrolled I will incur additional **LIFETIME** penalties for **EACH YEAR** I do not enroll.
- I understand that I will be required to complete and submit this affidavit at every eligibility determination until I obtain eligible insurance coverage.

Client Signature (age 12 and older) **Date**