DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-00851 (06/2018)

STATE OF WISCONSIN
AIDS/HIV Program
1-800-991-5532
FAX: 608-266-1288

AIDS/HIV DRUG ASSISTANCE AND INSURANCE ASSISTANCE PROGRAM
SIX-MONTH VERIFICATION

[First Name] [Last Name]
[Address]
[City, State Zip]

Dear [First Name]:

According to our records, you are currently enrolled in ADAP and/or IAP. In order to continue receiving assistance, you are required to complete this form. Failure to complete this form may result in termination of your assistance. **The deadline to complete and submit this form is September 30, 2018.**

SIDE A

By checking each item below, I verify that each statement is true.

- ☐ I currently live in the state of Wisconsin.
- ☐ My address has not changed since my last ADAP certification.
- ☐ My household income has not changed since my last ADAP certification.
- ☐ My household size has not changed since my last ADAP certification.
- ☐ My insurance situation has not changed since my last ADAP certification.

If you can verify that all of the above statements are true, please sign below and return.

If one or more of the statements above is/are NOT true, then complete SIDE B, attach appropriate documentation and sign below.

I hereby certify that all the information I have provided in this report form is true and complete. I understand that I am subject to termination of my enrollment eligibility and possible prosecution under state and federal laws if this information is false.

SIGNATURE – Applicant or Guardian	Date Signed

Return both sides of this form in an envelope marked “CONFIDENTIAL” to:

Division of Public Health
Attn: ADAP
PO Box 2659
Madison, WI 53701-2659
Or fax it to (608) 266-1288

To avoid termination of your benefits, complete sign and return this form by September 30, 2018

SIDE B

Complete this side if you have any changes since your last certification, or have not checked all boxes on Side A.

If you have moved since your last certification, you must provide proof of the new address, such as a lease, updated driver's license, or utility bill in your name.

STREET ADDRESS			**MAILING ADDRESS** (if different than Street Address)		
Street Address		Apt/Unit No.	Street Address		Apt/Unit No.
City	State	Zip Code	City	State	Zip Code

Home telephone	Cellular telephone
( )	( )
Is it okay to leave a message at this number? ☐ Yes ☐ No	Is it okay to leave a message at this number? ☐ Yes ☐ No

INCOME AND WAGES

Check all forms of income you receive, and provide appropriate documents for you and/or your spouse:

☐ **Employment -** *Submit a statement from your or your spouse's employer or paychecks that you or your spouse received within the last 60 days.*

☐ **Self-employment -** *Submit your most recent tax forms.*

☐ **Other income (Social Security, Unemployment, Worker's Compensation, Pension, Retirement, Alimony Received and/or income from Dividends or Interest) -** *You may submit this year's award letter, tax forms, or statement of benefit for you and/or your spouse.*

☐ **No income –** *Indicate how you are supported (family, friends, public assistance, etc.).*

I am supported by: ______________________________

Household Size

If your household size has changed, please list the number of people living in your home. Only include yourself, your spouse and/or legal dependents. ________

Insurance

If your insurance has changed since your last application please contact both your case manager and ADAP staff to report changes.

To avoid termination of your benefits, complete sign and return this form by September 30, 2018