



HIV Services Program

2015 Six-Month Client Recertification

Client's Name: _____ Soundex#: _____

Physical Address: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: (Home, Work, CELL) _____

Employment: _____

Current income documentation required – Photocopy of:

- **last 3 paychecks; or**
- **W2; or**
- **bank statement-3 months; or**
- **Social Security allocation letter; and**
- **Food Stamp benefit statement (if applicable)**

Other documentation required – Photocopy of:

- **Front and Back of ALL Insurance Cards - including Medicare A, B and D, Employer insurance, Marketplace Plan, VA benefits, Dental, Vision, or any other insurance coverage**
- **If client does not have insurance and they do not enroll in a Marketplace plan, they must complete the Affidavit of Declining Federally Facilitated Marketplace (FFM) form.**
- **Valid photo ID**

Medications taken in the last 6 months:

Medication: _____ Dr: _____ Date: _____

Use back of form for additional medications

Date of last CD4: _____

Value if known: _____

Date of last Viral Load: _____

Value if known: _____

Client Signature

Date

Case Manager Signature

Date