Wyoming Department of Health

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Thomas O. Forslund, Director **Governor Matthew H. Mead**

HIV SERVICES PROGRAM
2015 INCOME VERIFICATION FORM

If Applicant indicated an income of zero on the HIV Services Application for Assistance, this form must be completed along with a letter of explanation signed by the Applicant explaining how he/she is able to live on zero income/cash assistance. **EITHER** Section I **OR** Section II may be completed; completion of both sections is not required.

SECTION I - - ASSISTANCE PROVIDED TO APPLICANT

This section to be completed by the person providing residence and/or support.

I certify that the Applicant for services:

☐ receives $_____ per month from me as a regular contribution to his/her income

☐ is supported by me, in that I provide his/her housing, food, etc., and I ☐ do ☐ do not provide him/her with cash assistance.

By signing this form, I affirm that the above information is an accurate statement of assistance. I understand that if I deliberately omit or give false information, the Applicant may be removed from the Program, prosecuted under applicable state and federal statutes, or both.

SECTION II - - NO ASSISTANCE PROVIDED TO APPLICANT

This section to be completed by a social worker or by a public health nurse only. The social worker or public health nurse completing this section must be unrelated to the Applicant and may not live in his/her household.

To the best of my knowledge, information, and belief,_____, nor any member of his/her household, has any cash income or receives any outside non-cash assistance.

By signing this form, I affirm that the above information is an accurate statement of income. I understand that if I deliberately omit or give false information, the Applicant may be removed from the Program, prosecuted under applicable state and federal statutes, or both.

SIGNATURE: _____

PRINTED NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE NUMBER: _____ DATE: _____

Public Health Sciences Section
6101 Yellowstone Road, Suite 510 • Cheyenne WY 82002
(307) 777-5856 • FAX (307) 777-7382
www.health.wyo.gov