Wyoming Department of Health
Commit to your health.

Communicable Disease Treatment Program

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 <u>ALL</u> Insurance Cards - including Medicare A, B and D, Employer insurance, Marketplace Plan, VA benefits, Dental, Vision, or any other insurance coverage***
- ***Client Housing Plan***
- ***Valid photo ID***

Medications taken in the last 6 months:

Medication: _____ *Dr:*_____ *Date*:_____
Medication: _____ *Dr:*_____ *Date*:_____
Medication: _____ *Dr:*_____ *Date*:_____
Medication: _____ *Dr:*_____ *Date*:_____
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**