FINANCIAL ELIGIBILITY FORM

INSURANCE ASSISTANCE SECTION

Applicant's Name (First, MI, Last)	Date of Birth (mm/dd/yyyy)	Mother's Maiden Name
Marital Status ☐ Single ☐ Married ☐ Registered Domestic Partner ☐ Other_____	Household Size (Including applicant)	

Applicants who have an adjusted gross income at or below $50,000 need only to submit their income information and documentation. Applicants with income above $50,000 must also submit their spouse's income and documentation. Income eligibility will be based on half the combined income.

Adjusted gross income as stated on applicant's federal or state income tax return:
Applicants Income_____ Spouse's Income _____ **Total Adjusted Gross Income $ _____**

Applicants without a tax return must identify all sources of income and provide the amounts from the applicant's and if applicable spouse's income documentation. If income is not reported as an annual amount, annualize the income (i.e., weekly income x 52)

Source of Income	**Please check all that apply**		**How much income/money is received?**		**How often is income/money received?** (i.e., weekly, monthly)		**Gross Annual Household Income**
	Applicant	Spouse	Applicant	Spouse	Applicant	Spouse	
Employment							
Self-Employment							
SSI/SSA							
Social Security Disability Insurance (SSDI)							
State Disability Income (SDI)							
General Assistance/General Relief							
Private Disability							
Unemployment Insurance (UI)							
Retirement/Pension							
Worker's Compensation							
Investment or Interest Income							
Veteran's Administration (VA) Benefits							
Alimony							
Other							
						Total Gross Income	**$**

Identify the income documentation provided by checking all that apply:

☐ **Federal Income Tax Return*** ☐ **Disability Award Letter** ☐ **Benefit Receipt or Check Stub****
☐ **California State Tax Return*** ☐ **Support Verification Form** ☐ **Pay Stub****
☐ **W-2 or 1099 Tax Form** ☐ **Self-Employment Form** ☐ **Bank Statement** (clearly states income source)**

*** Copies of Schedule C, W-2 or 1099 tax forms must be included with tax return documents.**
**** Must provide documentation for 3 current consecutive months.**

Please note that the information on this form is being collected to determine eligibility for benefits under the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87) and is required by the California Department of Public Health (CDPH), Office of AIDS (OA). The information may be used to determine eligibility for insurance assistance. Failure to provide the mandatory information may result in the application not being processed. You have the right to review the information maintained by CDPH unless access is exempt by law. To access the information, contact CDPH Insurance Assistance Section, MS 7704, P.O. Box 997426, Sacramento, CA 95899-7426, or by phone at (800) 367-2437.

I certify that the answers I have given in this form and the documents provided are true and correct to the best of my knowledge. I understand that failure to provide accurate information may result in termination of insurance premium assistance. I also understand that CDPH/OA staff are permitted to request additional income verification if income reported appears to be inconsistent or incorrect.

_____ _____
Applicant's Signature Date