

## SUPPORT VERIFICATION FORM INSURANCE ASSISTANCE SECTION

**The following information is required for applicants who are being supported by another individual/agency, or who are homeless and unable to provide proof of income or residency.**

### I. Applicant Information

Applicant's Name (First, MI, Last)		Date of Birth (mm/dd/yyyy)		Mother's Maiden Name	
Home Address (Number, Street, Apt #)		City	County	State	Zip Code
Mailing Address (if different than home)		City	County	State	Zip Code
Telephone Number (Home):			Telephone Number (Alternate):		

Check here if currently homeless

**The following information is to be completed by any individual who is providing support to the applicant.**

### II. Support Information

The applicant named above receives the following from me:

Housing                       Utilities                       Food                       Cash

I expect to continue to provide these items until:

My relationship to the person named above is:

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 information provided on this form is true and correct to the best of my knowledge.

\_\_\_\_\_  
Printed Support Provider's Name

\_\_\_\_\_  
Signature of Support Provider

\_\_\_\_\_  
Date

**The following section is to be completed by the agency representative of an agency that provides support and who is able to verify the client's living situation**

The above named person receives the following services from this agency:

Shelter                       Social services                       Other \_\_\_\_\_

I certify that the above named person is (check all that apply):  Homeless with no source of income,  Homeless, but a resident of California,  Other \_\_\_\_\_

Agency Name		Agency Representative		
Agency Address (Number, Street, Suite #)		City	State	Zip Code
Agency Telephone Number		Agency Fax Number		