

SELF-EMPLOYMENT AFFIDAVIT INSURANCE ASSISTANCE SECTION

This form is to be completed by self-employed applicants who are unable to provide tax records and/or pay stubs to establish annual income.

Applicant's Name (First, MI, Last)	Date of Birth (mm/dd/yyyy)	Mother's Maiden Name
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I am self-employed. I have listed my total earnings for the past three months from _____ to the present as follows: Month/Year

Month/Year	Type of Work	Monthly Income \$
Month/Year	Type of Work	Monthly Income \$
Month/Year	Type of Work	Monthly Income \$
Total (sum of the three months listed) \$		Estimated Total Gross Income (multiply total by four) \$

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 will 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 on this form is 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. Furthermore, I agree to immediately notify the Insurance Assistance Section of any changes in my annual income.

Applicant's Signature	Date
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