

## IDENTIFICATION VERIFICATION FORM INSURANCE ASSISTANCE SECTION

**The following information is required for applicants who are unable to provide proof of identification.**

### 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):		

I certify that I have no proof of identification

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.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

**The following section is to be completed by the clinician providing the applicant's medical care.**

### II. Clinician Information

I certify that I am the applicant's clinician.

I certify that the applicant is under my care using the full name of \_\_\_\_\_

\_\_\_\_\_  
Clinician's Name (Printed)

\_\_\_\_\_  
License Number

\_\_\_\_\_  
Clinician's Signature

\_\_\_\_\_  
Date

**The following section is to be completed by the applicant's enrollment worker.**

### III. Enrollment Worker Information

I certify, to the best of my knowledge, that the applicant's full name is \_\_\_\_\_

Enrollment Site Name	Enrollment Worker Name		
Enrollment Site Address (Number, Street, Suite #)	City	State	Zip Code
Enrollment Site Telephone Number	Enrollment Site Fax Number		

\_\_\_\_\_  
Enrollment Worker's Signature

\_\_\_\_\_  
Date