COMMONWEALTH of VIRGINIA

Department of Health

Virginia Ryan White Part B Program

No Income Verification Letter

I understand that _____ is receiving medication assistance

Name of Applicant

from the Virginia Department of Health (VDH). To the best of my knowledge, the applicant has no income and I certify this to be true. I am either providing the applicant with food and shelter or providing the applicant with financial support.

_____

(My relationship to the applicant-for example: friend, cousin)

I am providing (check one):

- ☐ Food and Shelter
- ☐ Financial Support $_____ approximate amount per month

_____ _____

Signature of person providing support Printed name of person providing support

_____

Address

_____ _____

Telephone number Date

If you have any questions, please contact the Eligibility & Medication Call Center at **1-855-362-0658**. Please upload this document into the Provide Enterprise system.