VDH VIRGINIA DEPARTMENT OF HEALTH

Client Attestation to Low Income

Virginia Ryan White Part B Program

I attest that I earn cash income that is not verifiable by other means in the amount of _____ per _____ (week/bi-weekly/2x month/monthly).

I understand that I am to let my case manager know as soon as this information changes. I understand that if changes are not made known, or if the information provided is not complete, my access to Ryan White Part B funded services may be discontinued or denied.

Client Printed Name:

Client Signature:

Date: