Rhode Island EOHHS Drug Assistance Program Self-Attestation Form for Recertification

Full Legal Name (Last):	**(First):**	**(MI):**	Has this changed in the last 6 months? ☐ Y ☐ N
Social Security #: _____-_____-_____	**Gender:**	**Marital Status:**	**Sexual Orientation:**
Date of Birth_____/_____/_____(MM/DD/YYYY)			
At what phone number can we reach you during daytime hours? **Phone Number** ( ) ☐ Home ☐ Work ☐ Cell Phone **May we leave a message on this phone?** ☐ Y ☐N			
Home Address: * (Mailing Address-Must be a RI address)			
Case Manager Name:		**Case Manager Organization:**	
Case Manager Signature:_____		**Date:**_____	

By initialing below, I attest that each statement is true (initial each item separately):

_____ I currently reside in the State of Rhode Island.

_____ My household income has not increased or changed since my last ADAP application.

_____ My household size has not changed since my last ADAP application.

_____ My enrollment in or eligibility for Medicaid, Medicare, or health insurance (individually or through my employer, spouse, or other individual) has not changed since my last ADAP application.

_____ I understand that this self-attestation I am submitting is accurate and completed to the best of my knowledge. This Self Attestation Recertification Form, with required documentation (if applicable), is for the continuation of my Drug Assistance Benefits through the EOHHS Drug Assistance Program.

_____ The EOHHS Drug Assistance Program Enrollment Certification and Authorization of Release of Information which I signed as part of my last application continues to be in effect until I sign and complete a new ADAP Recertification Form.

By signing below, I certify that the information provided on this form is complete and accurate, to the best of my knowledge. I further certify that I know of no other factor or circumstance that would result in my loss of eligibility for EOHHS Drug Assistance Program. I certify that the information provided in this application is true and correct as of the date below and acknowledge that any intentional or negligent misrepresentation of the information may result in nullification of this application and liability for money granted. **I also understand that this program is a payer of last resort, meaning that I must exhaust all other possible sources of payment for these services before applying for this program.** Lastly, I understand that it is my responsibility to provide EOHHS with truthful information and documentation about my financial, employment, insurance, and HIV status.

_____ _____

Applicant Name Applicant signature

Return this completed form by email to both: Denise.cappelli@ohhs.ri.gov **&** Alix.Bernado@ohhs.ri.gov**Mail to:** Executive Office of Health & Human Services ⬬ Virks Building, Suite 227 ⬬ 3 West Rd. Cranston, RI. 02920 ⬬
Fax to: 401-462-3297