DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-00851 (07/2020)

STATE OF WISCONSIN
AIDS/HIV Program
1-800-991-5532
FAX: 608-266-1288

AIDS/HIV DRUG ASSISTANCE AND INSURANCE ASSISTANCE PROGRAM
SIX-MONTH VERIFICATION

Name
Street Address
City, State and Zip Code

According to our records, you are enrolled in ADAP and/or IAP. You must complete this form to continue getting assistance. If you do not, your coverage will end. **You must submit this form by September 30, 2020.**

SIDE A

By checking each item below, I verify that each statement is true.

- ☐ I currently live in the state of Wisconsin.
- ☐ My address has not changed since my last ADAP application.
- ☐ My household income has not changed since my last ADAP application.
- ☐ My household size has not changed since my last ADAP application.
- ☐ My insurance situation has not changed since my last ADAP application.

If all of the above statements are true, please sign below and return.

If any of the statements above are NOT true, then complete SIDE B, attach proper documents and sign below.

I hereby certify that all the information I have provided in this report form is true and complete. I understand that I am subject to termination of my enrollment eligibility and possible prosecution under state and federal laws if this information is false.

SIGNATURE – Applicant or Guardian _____ Date Signed _____

Return both sides of this form in an envelope marked “CONFIDENTIAL” to:

Division of Public Health
Attn: ADAP
PO Box 2659
Madison, WI 53701-2659

Or fax it to (608) 266-1288

Complete, sign and return this form by September 30, 2020

SIDE B

Complete this side if you have any changes or have not checked all boxes on Side A.

ADDRESS
If you have moved, you must provide proof of the new address, such as a lease, updated driver's license or utility bill in your name.

STREET ADDRESS			**MAILING ADDRESS** (if different than Street Address)		
Street Address Apt/Unit No.			Street Address Apt/Unit No.		
City	State	Zip Code	City	State	Zip Code

Home Phone ( )	Cell Phone ( )
Is it okay to leave a message at this number? ☐ Yes ☐ No	Is it okay to leave a message at this number? ☐ Yes ☐ No

INCOME AND WAGES

Check all forms of income you receive, and provide proof for you and/or your spouse:

☐ **Employment –** *Submit paychecks that you or your spouse received within the last 60 days or 2019 W-2s.*

☐ **Self-employment -** *Submit your most recent taxes.*

☐ **Other income (Social Security, Unemployment, Worker's Compensation, Pension, Retirement, Alimony Received and/or income from Dividends or Interest) -** *Submit this year's award letter, taxes, or statement of benefit for you and/or your spouse.*

☐ **No income –** *Tell us how you are supported (family, friends, public assistance, etc.).*

I am supported by: _____

HOUSEHOLD SIZE
If your family size has changed, please list the number of people living in your home. Only include yourself, your spouse and/or legal dependents. _____

INSURANCE
If your insurance has changed, please contact both your case manager and ADAP staff to report changes.

Complete, sign and return this form by September 30, 2020