

**VERIFICATION OF INCOME STATEMENT
FOR ALL APPLICANTS**

I _____ (print applicant name) swear or affirm that I currently do not receive income of any type that has not already been reported in my application for the OHIO HIV Drug Assistance Program (OHDAP). I understand that income includes all money received from work, even that which is not reported for tax purposes. Income also includes, but is not limited to, money received from retirement, investments, unemployment compensation, and disability benefits. I am aware that I must also report any and all income earned by a married spouse (if married) and parents (if a dependent).

I am aware that providing false, incomplete or inaccurate information regarding income or any other aspect of the Ohio HIV Drug Assistance Program (OHDAP) application may result in my inability to receive further assistance from any and all Ryan White Care Act funded programs.

Applicant Signature

Date (mm/dd/yyyy)

To help avoid treatment delays, please fax this form PROMPTLY along with a fully completed OHDAP Application to:

Ohio Department of Health/HIV Care Services Section

246 N. High Street, 6th Floor
Columbus, OH 43216-0118
800-777-4775 (Phone)
866-448-6337 (Fax)