Mary Washington Healthcare

Wellness Center

Six Month Self-Attestation Recertification Form for Ryan White Eligibility

Client Name: _____

Date of Birth: _____ Phone Number: _____

Address change ☐ No or ☐ Yes (If yes, write in new address below and have client provide updated proof of residency)

New Address: _____

INCOME:

Please check one: ☐ I have no income ☐ My income has not changed ☐ My income has changed

If your income has changed since your last recertification 6 months ago, please include appropriate documentation of three consecutive paystubs, Social Security letter, current tax return or support statement.

INSURANCE STATUS:

☐ Medicaid ☐ Medicare ☐ Medicare Part D ☐ Private Insurance ☐ VA MAP
☐ No Form of Insurance

If your insurance coverage has changed, please send back to us front and back copies of your insurance cards.

I attest that my signature on this form indicates the information provided is accurate and complete to the best of my knowledge.

Signature: _____ Date: _____

Witness Signature: _____ Date: _____

- Agency Use Only -

Agency/Program Conducting 6 Month Recertification:

Mary Washington Healthcare

Staff Member and Title of Person Conducting 6 Month Recertification:

_____

Next Recertification Date:

_____

Mary Washington Healthcare

Wellness Program | Ryan White Grant

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA PRIVACY

I, _____, understand that Mary Washington Healthcare (MWHC), of which the MW Wellness Program | Ryan White Grant (The Program) is a wholly-owned subsidiary, may use and disclose my protected health information for purposes of treatment, payment and health care operations. I also acknowledge that I have received, have been offered, or have received in the past a copy of the Notice of Privacy Practices for MWHC, which provides information about how the physicians, facilities and individuals involved in my care may use and disclose my protected health information. As provided in the Notice, the terms of the notice may change. To obtain a copy of any current Notice, I may contact the Privacy Officer at 1-800-442-8762.

I understand that I have the right to request that The Practice restrict how my protected health information is used or disclosed for treatment, payment or health care operations, but I also understand that The Practice is not required to agree to a requested restriction.

AUTHORIZATION TO RELEASE INFORMATION

I authorize Mary Washington Healthcare (MWHC), of which the MW Wellness Program | Ryan White Grant (The Program) to leave messages regarding my treatment; including lab results, x-rays, names(s) of medication(s), information pertaining to my treatment and/or office updates by the following method (please circle Yes or No):

Yes No Home answering machine: _____ **Yes No** Cell Phone/Voicemail: _____
Yes No Work Voicemail: _____

I authorize Mary Washington Healthcare (MWHC), of which the MW Wellness Program | Ryan White Grant (The Program) to release any information regarding my treatment; including lab results, x-rays, names(s) of medication(s), information pertaining to my treatment and/or office updates. This includes leaving message(s) on the designated contact(s) phone number. Mary Washington Healthcare (MWHC), of which the MW Wellness Program | Ryan White Grant (The Program) may not release information to the named individuals and or entities unless you identify them below.

Name	_____	Relationship to Patient	_____	Contact Info	_____
Name	_____	Relationship to Patient	_____	Contact Info	_____
Name	_____	Relationship to Patient	_____	Contact Info	_____
Name	_____	Relationship to Patient	_____	Contact Info	_____

Mary Washington Healthcare (MWHC), of which the MW Wellness Program | Ryan White Grant (The Program) will use my home phone number and primary address supplied during registration to contact me regarding my treatment; including lab results, x-rays, names(s) of medication(s), and information pertaining to my treatment and/or office updates.. I will ensure this information is up to date at every visit.

Patient Name: _____ **DOB:** _____ **Patient Account#:** _____

Patient Signature: _____ **Date:** _____

Patient Representative: _____ **Relationship to Patient:** _____