Certification of Justice-Involved Client Eligibility

Instructions

For use at a county jail enrollment location only. An enrollment worker may use this form to attest to an AIDS Drug Assistance Program (ADAP) applicant's eligibility when the individual is unable to provide the required documents to establish his or her identity, residency, and income due to temporary detention in a county facility. This form must be submitted along with:

•*Signed Consent Form CDPH 8685 (Spanish*
•*Signed* Client Attestation Form CDPH 8723 Spanish
•*Proof of HIV Diagnosis (If lab is not available, use form CDPH 8440*

Applicant Information

Name:_______________________________________ Date of Birth:____________________

Address:______________________ City:__________________ State:_____ Zip Code:______

- **Identity:** I attest that I do not have access to any identification documents to verify my identity. I hereby grant the enrollment worker named below permission to attest to my identity. I attest that, to the best of my knowledge, the information provided in this form, and in all other documents submitted in conjunction with this form, is true and accurate. I understand and hereby acknowledge that CDPH may request additional documentation to verify my identity if there is reason to believe additional verification is necessary.
- **Residency:** I hereby certify that I currently reside in the state of California, and that the information included on this application is factual, accurate, complete, and I agree to immediately notify CDPH of any changes in my residency.
- **Income:** I hereby certify that I have no income source, and I am not eligible for Medi-Cal. I agree to immediately notify CDPH of any changes in my income. I understand that as a condition of participating in the program, CDPH will verify my income with the California Franchise Tax Board. I also understand that CDPH is permitted to request additional income verification if income reported appears to be inconsistent or incorrect.

I understand that failure to provide accurate information or deliberately omitting information may result in suspension or termination of services and I may be held financially responsible for any covered services obtained.

Applicant Signature:______________________________ Date:________________________

Enrollment Worker Information

Name:_______________________________________ AES User ID:____________________

Enrollment Site Number:__________________________

I attest that the above-named applicant has been a detainee at the site location indicated above since ___________________________(enter date), and that he or she is unable to submit any eligibility documents related to identity, residency, and/or income level. I certify that as an enrollment worker, I have sufficient information related to the above-named applicant to attest to his or her identity, residency, and income level. The applicant is not eligible for Medi-Cal and is not eligible to receive services through another health insurance plan or support service.

Enrollment Worker Signature:___________________________ Date ______________________