LOUISIANA HEALTH ACCESS PROGRAM CERTIFICATION OF NO INCOME/CASH-ONLY INCOME

Please print clearly. If you need assistance completing this form, please contact LA HAP at 504-568-7474. The form may be attached to your LA HAP application and mailed to 1450 Poydras St, Suite 2136, New Orleans, LA 70112 or faxed to 504-568-3157.

If no other documentation of income is available, this form can be used to certify zero income OR cash-only income when applying to or recertifying for the Louisiana Health Assistance Program (LA HAP). **This form may NOT be used to certify any income besides cash payments.**

First Name:	**Last Name:**	**Date of Birth: ___/___/_____**

NO INCOME VERIFICATION (to be completed by applicant)

☐ **I certify that I currently do not have any income,** including through employment or from other sources (like unemployment, interest, retirement, Social Security/Disability (SSDI), Supplemental Security (SSI), etc.).

Please provide a brief summary describing the current living conditions/arrangements that apply:
(examples: I support myself but living with family/friends that only provide housing and/or food, living in a homeless shelter, living in rehabilitation center, etc.)

CASH-ONLY INCOME VERIFICATION (to be completed by applicant)

☐ **I certify that I receive cash income,** and that NO OTHER DOCUMENTATION (pay stubs, receipts, tax return, letter from employer, etc.) is available to me.

Through cash payments, I earn approximately $_____ per pay period.

My pay period is (check ONE): ☐ hourly ☐ daily ☐ weekly ☐ monthly ☐ other: _____

My work frequency is (X hours per month, X months per year, etc.): _____

Select one: ☐ The cash income above is my only source of income. ☐ I have other income in addition to cash income, and I am including documentation of that income in my LA HAP application.

CERTIFICATION (to be completed by applicant)

By initialing to the left of each statement and signing below, I agree that:

_____I understand that verification of income is required to determine eligibility for all Ryan White programs, including the Louisiana Health Access Program (LA HAP) components Louisiana Drug Assistance Program (LDAP) and Health Insurance Program (HIP).

_____I understand that the program I am applying for may verify the information on this form and I may be required to submit additional documents, if requested. Failure to do so within the specified deadline will result in my file being closed to the program.

_____I understand that if my income changes, I must notify LA HAP immediately.

_____I understand that if I deliberately misrepresent information on this form, I may be required to repay benefits to the program and I may be prosecuted under applicable state and federal statutes.

_____To the best of my knowledge the above information is accurate and complete as of today's date. I understand that in order to confirm my eligibility for LA HAP, my information may be shared with but is not limited to the following: physician, health department personnel, treatment center personnel, pharmacy services provider, referral source, clinic, insurance broker and/or insurance carrier, Medicare, Medicaid CMS, SSA, SSDI, and other Louisiana agencies from which I receive Ryan White services.

Applicant (Print Name) Applicant Signature Date

Entity Representative: By signing below, I certify that the purpose of this form and the above Client Certification & Release has been explained to the client, and that to the best of my knowledge the above information is accurate and complete as of today's date.

Entity Representative or Witness (Print Name) Entity Representative or Witness Signature Date