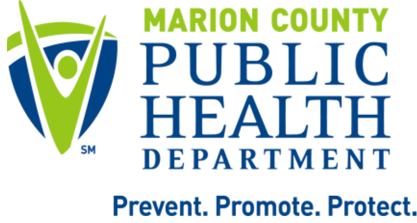
Client ID#



Care Coordination Site
☐ Concord ☐ Damien Ctr.
☐ IU H/Life Care ☐ Step-Up
☐ Eskenazi
Care Coordinator: ____________________________________

No Tax Return Form

Name (First, MI, Last):	Date of Birth: _____/_____/_____ Month Day Year	Social Security number _____-_____-_____

This letter certifies that the above named client is a client at the care coordination site listed above and is requesting services from Marion County Public Health Department's Ryan White HIV Services Program (MCPHD RWSP).

The above mentioned client did not file taxes for the ___________tax year.

I, ______________________________ certify that the above named client did not file taxes and the number of people in the household as noted on the enrollment/recertification/re-entry application is correct.
CC/CM

I, ______________________________ understand that any information found to be falsified will render me ineligible for the MCPHD Ryan White HIV Services Program.
Client Name

Client Signature: ____________________________________ _____/_____/_____
Date of Birth

Client's Social Security#: _____-_____-_____ _____/_____/_____
Date

CC/CM Signature: ____________________________________

Care Coordination Site
☐ Concord ☐ Damien Ctr.
☐ IU H/Life Care ☐ Step-Up
☐ Eskenazi

Date:_____/_____/_____