Ryan White Part B Program Application Form (*October 2017*)

Office Use Only: CM Agency: ☐ C1A ☐ UAF Assisted Client with Application:______________________________

Case Manager Contact for Application Follow-Up:______________________________

☐ DPI ☐ MP ☐ Employer ☐ COBRA ☐ Medicare Part D ☐ ADAP-M ☐ CM Only

☐ Supportive Service(s): ______________________________

Application Reason *select one or more*:

☐ Establishing Care ☐ Lost Medicaid ☐ Seeking Supportive Service(s)
☐ New to Medications ☐ Newly Unemployed ☐ Other______________________
☐ New Diagnosis ☐ Previously Over Income ______________________
☐ New to Utah ☐ Recently Released from Prison ______________________

☐ Request to Expedite by: _______/_________/___________

1. Applicant Information

Date of Birth:____/____/_____ C1A MRN:______________________ ☐ UAF Not Applicable

Legal Name (Last, First, Middle):______________________________ Sex at Birth: ☐ Male ☐ Female

Preferred Name:__________________________ Social Security #:_________-_______-__________ ☐ NA ☐ Refused

Current Gender: ☐ Male ☐ Female ☐ Transgender (Male to Female) ☐ Transgender (Female to Male) ☐ Refused

Race *select one or more:* ☐ White ☐ Black or African American ☐ Asian
☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander

Ethnicity *select one:* ☐ Non-Hispanic / Latino/a or Spanish origin ☐ Hispanic / Latino/a or Spanish origin

Race & Ethnicity Subgroups *select one or more:*

☐ These race and ethnicity subgroups <u>do not apply</u> to me.

☐ Hispanic: ☐ Mexican, Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other Hispanic

☐ Asian: ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian

☐ Native Hawaiian or Other Pacific Islander: ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander

2. Applicant Contact Information

☐ Do not contact me by mail

Physical Address: Street:______________________________ Apt #:__________

City:______________________ County:______________________ State:________ ZIP:__________

Mailing Address *(If different from Physical Address):* Street or PO Box______________________________

Apt #:________________ City:______________________ State:______ ZIP:______________

Preferred Phone #:______________________ E-mail:______________________________

The Program has my permission to text and/or e-mail me: ☐ Yes ☐ No

3. HIV Status *To be completed by Medical Provider*

Provider Name:______________________________ Will patient be prescribed ART? ☐ Yes ☐ No

HIV Status: ☐ HIV+, not AIDS ☐ HIV+, AIDS status unknown ☐ CDC-defined AIDS ☐ HIV Indeterminate (infants < 2 yrs)

HIV+ Diagnosis Date: ____/____/_______(mm/dd/yyyy) AIDS Diagnosis Date: ___/______/_______(mm/dd/yyyy)

Initial Risk Factor(s) for HIV Infection *select one or more*:

☐ Male who has sex with male(s) ☐ Hemophilia/coagulation disorder
☐ Injection drug use ☐ Perinatal transmission
☐ Heterosexual contact ☐ Not reported or not identified
☐ Receipt of transfusion of blood, blood components, or tissue

Provider Signature:______________________________ Date:____________________

4. Proof of Utah Residency

Submit <u>at least one</u> of the following documents that features your name and your Utah street address:

- Bill
- A document issued by the State of Utah
- A document issued by the United States Federal Government
- Bank Statement
- Rent / Mortgage Agreement
- Current Utah ID
- Current Utah Driver License
- Homeless Shelter Voucher
- Federal IRS Tax Transcript
- Paystub/Earnings Statement
- Statement of Support
- Official Medical Documentation

5. Housing Status

☐ Stable Permanent Housing ☐ Temporary Housing ☐ Unstable Housing

6. Assets

of registered vehicles you own (just you, not your spouse or other family/household members):______________

# of homes you own (just you, not your spouse or other family/household members): ____________________

7. Household Size & Marital Status

Married: ☐ No ☐ Yes Spouse name, if also applying:________________________ Household Size:____________

8a. Proof of Income

Do you (just you, not other household members) receive an income? ☐ No ☐ Yes

If YES, are you employed? ☐ No ☐ Yes

If YES, do you work 30 or more hours per week? ☐ No ☐ Yes

Does your spouse receive an income? ☐ No ☐ Yes ☐ Not married ☐ I'm separated; I receive no financial support from my spouse

If YES, is your spouse employed? ☐ No ☐ Yes

If YES, does your spouse work 30 or more hours per week? ☐ No ☐ Yes

Submit at least one of the following documents that verifies your household income.
If you are married, you are also required to provide verification of your spouse's income.

- Affidavit of Zero/Informal Income—***complete section 8b on the next page*** (i.e., your household receives none of the listed sources of income, or income from any other source). *If you are married, an Affidavit of Zero Income is not required from your spouse if they have no income. You are instead required to indicate you are married with no spousal income on this application form.*
- One (1) current Paystub/Earnings Statement
- Forms/documentation that verify self-employment income (e.g., IRS Form Schedule C or E)
- Social Security/Disability Letter or Bank Statement documenting consistent and consecutive Social Security/Disability deposit amounts
- Supplemental Security Income (SSI) Letter or Bank Statement documenting consistent and consecutive SSI deposit amounts
- Unemployment Statement from the Department of Workforce Services (DWS)
- General Assistance Letter from DWS
- Pension Letter
- I do not receive any of the listed sources of income. My spouse or other household member(s) does receive income. *If you are married, an Affidavit of Zero Income is not required from you if your spouse has income and you do not. You are instead required to indicate you are not employed on this form and submit your spouse's income documentation.*

MONTHLY INCOME AMOUNT
Enter information below for your income. Write $0 if none.

Wages/Salary__________________ Commission/Tips_______________ Unemployment________________________

Pension/Retirement_____________ Social Security_________________ Interest Dividends______________________

Other Income__________________ General Assistance_____________ Rent other people pay you______________

Enter information below for all other household members. Include your spouse's income. Write $0 if none.

☐ Not applicable; my household size is 1.

Wages/Salary__________________ Commission/Tips_______________ Unemployment________________________

Pension/Retirement_____________ Social Security_________________ Interest Dividends______________________

Other Income__________________ General Assistance_____________ Rent other people pay spouse___________

REQUIREMENT TO UPDATE AND COOPERATE: I understand that I am required to report any changes in income or money received, family composition and contact information (address, phone). I understand I am required to supply all information needed to determine my level of benefits or verify my true circumstances. Cooperation includes completion and execution of all required forms and releases. I understand that failure to cooperate or provide correct information may lead to either delays or denial/termination of services.

AUTHORIZATION TO VERIFY INFORMATION: I understand that all information on this form may be verified by the Ryan White Part B Program.

INFORMATION SUPPLIED IS TRUE AND COMPLETE: I certify all the information provided on this form is accurate and complete to the best of my knowledge. 18 USC 1001 provides, among other things, that whoever knowingly and willfully makes or uses a document or writing containing any false, fictitious, or fraudulent statement of entry, in any manner within the jurisdiction of any department or agency of the United States, shall be fined not more than $10,000, imprisoned for not more than five years, or both.

8b. Proof of Income

☐ *AFFIDAVIT OF ZERO INCOME*

I hereby attest that my household is not currently receiving or expecting to receive any of the income types listed below.

How do you pay for your financial obligations?____

____

☐ *AFFIDAVIT OF INFORMAL INCOME*

I hereby attest that my household is currently receiving or expecting to receive the income type(s) and amount(s) indicated below.

Source of informal income: ____

____

INSTRUCTIONS

Monthly amount must be indicated for each type of income, even if the amount is $0. Blank monthly amounts are unacceptable. The income type(s) and monthly amount(s) indicated below must match what is reported elsewhere on this application form to serve as income verification.

Type of Income	Monthly Amount	Type of Income	Monthly Amount	Type of Income	Monthly Amount
Wages & Overtime		Social Security Income		Child Support	
Sick or Vacation Pay		Social Security Disability		Alimony	
Unemployment		Welfare/TANF		Sale of Assets	
Self-Employment		Pension		Inheritances	
Tips		401(k) or IRA		General Assistance	
Commissions or Bonus		Annuity or Insurance Benefits		Veterans Administration	
Worker's Compensation		Interest or Dividends		Death Benefits	
Military Pay/Allowance		Severance Pay		Rent other people pay you/ spouse	
Cash Earnings		Other: (Please explain)			

9. Health Insurance

Select all of the health insurance types you have:

☐ Private-Individual (Direct Purchase / Marketplace / COBRA)
☐ Private-Employer
☐ Medicare Part A/B
☐ Medicare Part D
☐ Medicaid, Children's Health Insurance Program (CHIP), or other public plan
☐ Veterans Health Administration (VA), Tricare or other military health care
☐ Indian Health Services (IHS)
☐ Other Plan: ________________________________

☐ No health insurance / uninsured:
- ☐ I decline health insurance available to me.
- ☐ Open enrollment is currently closed and I have not had and do not foresee having a qualifying life event. I will enroll during next open enrollment.
- ☐ It is currently open enrollment and I need medications while pursuing health insurance (*30-day supply of meds*).
- ☐ I am newly establishing / re-establishing care and will work with my case manager to enroll (*30-day supply of meds*).
- ☐ My case manager has determined that I am not a good candidate for health insurance. *Your case manager must submit written justification.*
- ☐ I am eligible for insurance through my employer, COBRA, spouse, partner, parent, Medicare or the Marketplace. My coverage will be effective: _________/_____________/_____________
- ☐ Other *Your case manager must submit written justification.*

10. Medicaid

Are you enrolled in Medicaid?

☐ Yes, I am enrolled I have Primary Care Network (PCN): ☐ No ☐ Yes
- ☐ I have Pregnant Women's Program and coverage is estimated to end _____/_____/_____

☐ I applied, but was denied. Denial Reason:____
☐ I am still awaiting a decision about my Medicaid eligibility:
- ☐ Application pending submission
- ☐ Application submission date:___________________________

☐ No, I have not applied because:
- ☐ I am a non-disabled adult thus ineligible
- ☐ I am undocumented thus ineligible
- ☐ My income and/or assets exceed Medicaid eligibility requirements
- ☐ I am eligible for health insurance through my employer (including COBRA) thus ineligible
- ☐ I am eligible for health insurance through my spouse/partner/parent/other thus ineligible
- ☐ I enrolled through the Marketplace thus already screened for Medicaid and found ineligible
- ☐ Other reason(s) I have not applied for Medicaid *Your case manager must submit written justification.*

11. Employer, Spouse, Parent, Medicare or Marketplace Health Insurance

Do you have health insurance through an employer, COBRA, spouse, partner, parent, Medicare or Marketplace?

☐ No—complete section 11b on page 5
☐ Yes—complete section 11a below

11a. Health Insurance Coverage through an Employer, Spouse, Parent, Medicare or the Marketplace

I am enrolled in health insurance coverage through: ☐ Employer ☐ COBRA ☐ Spouse ☐ Partner ☐ Parent ☐ Marketplace ☐ Medicare ☐ Other:____________________

If you are not already enrolled but will be eligible to enroll in the future, then you will also need to submit plan detail and enrollment and effective date documentation.

Plan Name:____
Health Insurance Company Name:_____________________________
Policy Holder Name:_______________________________________
Effective Date:____
HIV Provider In-Network? ☐ Yes ☐ No
Access to HIV Medications? ☐ Yes ☐ No
Individual Out of Pocket Maximum:___________________________

11b. No Health Insurance Coverage through an Employer, Spouse, or Parent

No Employer Health Insurance

 I am unemployed
 My employer does offer it, but I am not eligible:
 I am undocumented
 It is a new job and I am eligible: **Documentation required*
Enrollment date ______/______/______
Effective date ________/______/______
 I missed the open enrollment period **Documentation required*
Enrollment date _________/______/______
Effective date ____/______/______
 I work part-time
 I work full-time, but am ineligible **Documentation required*
 Other **Documentation required*

 My employer does not offer it to anyone
 I am self-employed and do not offer it to anyone
 My employer does offer it, but:
 Coverage is insufficient **Documentation required*
 Coverage is unaffordable **Documentation required*
 I decline health insurance available to me and choose to be uninsured
 My case manager has determined that I am not a good candidate for health insurance **Documentation required*
 Other **Documentation required*

No Health Insurance through Spouse

 I am not married
 My spouse's employer does offer it, but I am not eligible:
 I am undocumented
 It is a new job and I am eligible: **Documentation required*
Enrollment date ______/______/______
Effective date ________/______/______
 I missed the open enrollment period **Documentation required*
Enrollment date _________/______/______
Effective date ____/______/______
 Spouse works part-time
 Spouse works full-time, but is ineligible **Documentation required*
 Other **Documentation required*
 My spouse is self-employed and does not offer it to anyone
 My spouse is deceased and I am not re-married

 My spouse is unemployed
 My spouse's employer does not offer it to anyone
 My spouse's employer does offer it, but:
 Coverage is insufficient **Documentation required*
 Coverage is unaffordable **Documentation required*
 I decline health insurance available to me and choose to be uninsured
 My case manager has determined that I am not a good candidate for health insurance **Documentation required*
 Other **Documentation required*
 My spouse refuses to offer it to me
 I am not in contact with my spouse
 I am separated; I receive no health insurance support from my spouse

No Health Insurance through Parent

 I am age 26 or older
 My parent(s) is unemployed
 I am not in contact with either of my parents
 My parent's employer does offer it, but I am not eligible:
 I am undocumented
 It is a new job and I am eligible: **Documentation required*
Enrollment date ______/______/______
Effective date ________/______/______
 I missed the open enrollment period **Documentation required*
Enrollment date _________/______/______
Effective date ___________/______/______
 Parent works part-time
 Parent works full-time, but is ineligible **Documentation required*
 Other **Documentation required*
 My parent(s) is self-employed and does not offer it to anyone

 My parent's employer does not offer it to anyone
 My parent(s) is deceased
 My parent(s) refuses to offer it to me
 My parent's employer does offer it, but:
 Coverage is insufficient **Documentation required*
 Coverage is unaffordable **Documentation required*
 I decline health insurance available to me and choose to be uninsured
 My case manager has determined that I am not a good candidate for health insurance **Documentation required*
 I decline being on my parent(s) plan **Documentation required if seeking insurance services*
 Other **Documentation required*

12. Authorization for Release of Information

☐ Not Applicable

☐ I hereby authorize the Utah Ryan White Part B Program to release information to the following individual(s):
Name (please print):____ Relation:______________________
Name (please print):____ Relation:______________________
Name (please print):____ Relation:______________________

This request and authorization applies to information gathered through Utah Ryan White Part B Program activities.

I understand that my records are protected under Federal regulations and cannot be disclosed without my written consent unless otherwise provided for under the regulations. This document serves as my consent for the release of information to the individual(s) set forth above. I also understand that I may revoke this consent at any time, in writing, except to the extent that action has been taken in reliance on it.

13. Client Rights & Responsibilities

Clients accessing ADAP Health Insurance (ADAP-I) Services:

The Utah Ryan White Part B Program (Part B Program) is helping to pay for my health insurance premiums, deductibles, co-insurance, and co-payments through ADAP-I services. I understand that I have the following responsibilities in order to continue receiving this help.

- I understand that I am the policyholder of my insurance plan being paid for by the Part B Program and I have the responsibility of sharing any letters, bills, and communication I receive from the insurance company with my case manager.
- I understand that I have the responsibility to re-certify with the Part B Program every six months or I risk having my insurance plan cancelled. If I do not re-certify I am considered ineligible for the Part B Program and I am responsible for paying back any Part B Program money spent on my insurance during the time I did not recertify, which may include monthly premiums, deductibles, co-insurance, and/or co-payments.
- I understand that if I receive a refund check from the insurance company that I have the responsibility to return this money to the Part B Program. I understand that if I do not make payment arrangements with the Part B Program I will not be eligible to continue receiving Part B Program services.
- I understand that if I receive a refund on my tax returns due to underpayment of premium tax credits through the Health Insurance Marketplace that I have the responsibility to return this money to the Part B Program. I understand that if I do not make payment arrangements with the Part B Program I will not be eligible to continue receiving Part B Program services.
- I understand that if I do owe the Part B Program any money due to insurance over-payment, failure to re-certify every six months, due to underpayment of premium tax credits on the Marketplace, or other reasons then I can enter into a payment plan to continue receiving help from the Part B Program.
- I understand that if I do not return any money owed to the Part B Program and do not arrange for payment, I will not continue receiving help from the Part B Program.

Clients with no health insurance accessing ADAP Medication (ADAP-M) Services:

If you do not have health insurance, for any reason, and want to keep getting services from the Ryan White Part B Program (Part B Program), including ADAP- Medication Assistance (ADAP-M), there may be serious consequences.

- Under the Affordable Care Act (ACA), the penalty for not having health insurance in 2017 is $695.00 per person or 2.5% of your yearly household income, whichever is more. The Part B Program **will not** help you pay this penalty. You will have to pay the penalty yourself. Some people may be exempt from the penalty (not have to pay). For example, if you do not make enough money to file a tax return, you may be exempt from the penalty.
- If you do not have health insurance and are enrolled in the Part B Program, then you will only be able to get medications listed on the ADAP-M Formulary and only be able to see Part B Program doctors and providers.
- If the Part B Program does not have enough money to help everyone, there will be people placed on a wait-list. The people who choose to not get health insurance but could have may have their place on the wait-list affected by this choice.

13. Client Rights & Responsibilities (continued)

Clients accessing any Ryan White Part B Program (Part B Program) service:

As a client of the Part B Program, you have the **right**:

- To be treated with respect, dignity, consideration, and compassion.
- To receive services free of discrimination on the basis of race, color, ethnicity, national origin, sex, gender identity, sexual orientation, religion, age, class, physical or mental ability.
- To receive information in terms and language that you can understand, and is culturally appropriate.
- To participate in creating a plan for services.
- To reach an agreement with your case manager about the frequency of contact you will have, either in person or over the phone.
- To withdraw your voluntary consent to participate in Case Management services without affecting your medical care or other benefits to which you are entitled.
- To be informed about services and options available to you, including the cost.
- To the assurance of confidentiality of all personal information, communication and records.
- To not be subjected to physical, sexual, verbal and/or emotional abuse or threats.
- To file a grievance about services you are receiving or denial of services, according to the Part B Program Grievance Policy.

As a client of the Part B Program, you have the **responsibility**:

- To treat other clients, volunteers, and staff with respect and courtesy.
- To protect the confidentiality of other clients you encounter.
- To be free of alcohol or mind altering drugs while receiving Part B Program services or when on the phone with a service provider.
- To participate in creating a service plan and to take an active role in resolving that plan.
- To let your case manager know any concerns you have about your case management plan or changes in your needs.
- To make and keep appointments to the best of your ability, or to phone to cancel or change an appointment time, whenever possible.
- To stay in communication with your case manager by immediately informing her/him of changes in your health, income, assets, health insurance, residency / address, phone number, marital status, household size, and/or living arrangements and by responding to your case manager's calls or letters to the best of your ability.
- To respond to Part B Program calls or letters to the best of your ability.
- To submit a complete re-certification application to the Part B Program every six months.
- To refrain from knowingly falsifying documentation or information related to eligibility.
- To refrain from causing physical, sexual, verbal, or emotional abuse or threats to clients, staff, or volunteers (including pharmacy staff).

I understand the above client rights, understand my responsibilities, and agree to comply with them. I understand that violation of these responsibilities may result in termination from the Part B Program. I understand the Part B Program Grievance Policy referenced. I understand that I may request and receive a copy of this Policy at any time.

*Please Note: The pharmacies where medications are dispensed to eligible ADAP clients are independent of the Part B Program. Each pharmacy network and/or individual pharmacy location reserves the right to refuse services to anyone, including eligible ADAP clients. If a pharmacy network or location exercises its' right to refuse services to an eligible ADAP client, that client will be required to receive pharmacy services elsewhere.

14. Disclosure Consent

I understand that my records are protected under State and Federal regulations and cannot be disclosed without my written consent. I understand that information can be released for billing, chart audits, program monitoring/quality management, data reporting, health insurance, and needs assessment purposes. This document serves as my consent for the release of information. I also understand that I may revoke this consent at any time, in writing, except to the extent that action has been taken in reliance on it.

15. Certification of Application Accuracy & Completeness

I certify that all information contained within and submitted with this application is true, correct, and complete to the best of my knowledge. I realize that providing false information may disqualify me from Ryan White Part B Program services. The Ryan White Part B Program cannot pay for services that have been paid or can reasonably be paid by any State, Federal or private entity that provides health benefits.

Applicant's Signature:____ Date:________________

If you have any questions, then please call:

Clinic 1A: 801-585-2670 Utah AIDS Foundation: 801-487-2323 Utah Department of Health: 801-538-6197