

**Ryan White Part B Program Application Form (September 2016)**

**Office Use Only:** CM Agency:  C1A  UAF CM Name: \_\_\_\_\_  
**Case Manager**  DPI  MP  Employer  COBRA  Med D  ADAP-M  CM Only  Supportive Service(s): \_\_\_\_\_  
 Eligibility Period:  April 2016—September 2016  October 2016—March 2017  
 Application Reason: \_\_\_\_\_  Expedited, new applicant needs to start meds immediately

**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:*  Hispanic / Latino/a or Spanish origin  Non-Hispanic / Latino/a or Spanish origin  
 Race & Ethnicity Subgroups *select one or more:*  
 These race and ethnicity subgroups  Hispanic:  Mexican, Chicano/a  Puerto Rican  Cuban  Other Hispanic  
 Asian:  Asian Indian  Chinese  Filipino  Japanese  
 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 at this address.  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ E-mail: \_\_\_\_\_  
 The Program has my permission to text and/or e-mail me:  Yes  No  NA

**3. HIV Status** *To be completed by Medical Provider*  
 Provider Name: \_\_\_\_\_ Patient 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 at least one of the following documents that features your name and your Utah street address:  
 Bill  Utah ID  Official Medical Documentation  
 A document issued by the State of Utah  Utah Driver License  Statement of Support  
 A document issued by the United States Federal Government  Homeless Shelter Voucher  Federal IRS Tax Transcript  
 Bank Statement  Paystub/Earnings Statement  
 Rent / Mortgage Agreement

**5. Housing Status**  Stable Permanent Housing  Temporary Housing  Unstable Housing

**6. Household Size & Marital Status**  
 Married:  Yes  No Whether you file taxes or not, how many dependents do you claim (including self)? \_\_\_\_\_  
 My spouse has:  I am not married  Income  No Income Spouse name, if also applying: \_\_\_\_\_

**7. Assets**  
 # of registered vehicles you own (just you, not your spouse or other family/household members): \_\_\_\_\_  
 # of homes you own (include homes owned by you, your spouse, and/or other household members): \_\_\_\_\_  
 Enter information below for all household members. Write value of all you and your spouse own, even if amount is \$0.  
 If an asset is shared with someone not living in your household, enter the amount that belongs to you.  
 Checking AND Savings \_\_\_\_\_ Stocks/Bonds/CDs \_\_\_\_\_  
 Life Insurance/Annuities \_\_\_\_\_ Other Assets \_\_\_\_\_  
 Rent other people will pay you this year \_\_\_\_\_ Cash \_\_\_\_\_

**8a. Proof of Income**

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.

- One (1) current\* Paystub/Earnings Statement  
\*Current means dated within two (2) months of your complete application submission date.
- 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
- Affidavit of Zero/Informal Income—**complete section 8b below** (i.e., you receive 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.

**MONTHLY INCOME AMOUNT**

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

Wages/Salary _____	Commission/Tips _____	Unemployment _____
Pension/Retirement _____	Social Security _____	Interest Dividends _____
Other Income _____	General Assistance _____	

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) within 10 days and in writing. 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 on 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 I am not currently receiving or expect to receive any of the income types listed below within the next 30 days.

**AFFIDAVIT OF INFORMAL INCOME**

I hereby attest that I am currently receiving or expect to receive the income type(s) and amount(s) indicated below within the next 30 days.

**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		Veterans Administration	
Workmen's Compensation		Interest or Dividends		Death Benefits	
Military Pay/Allowance		Severance Pay			
Cash Earnings		Other: (Please explain)			

How do you pay for your financial obligations? \_\_\_\_\_

**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 *select all that apply:*
  - 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.
  - I am newly establishing / re-establishing care and will work with my case manager to enroll.
  - My case manager has determined that I am not a good candidate for health insurance. *Your case manager must submit written justification.*
  - 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):  Yes  No
- 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 undocumented thus ineligible
  - I am a non-disabled adult with no dependents thus ineligible
  - My income exceeds Medicaid income or asset eligibility requirements
  - I am eligible for insurance through my employer (including COBRA) thus ineligible
  - I am eligible for insurance through my spouse (including spouse’s employer insurance) 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. Health Insurance through an Employer, Spouse, or Parent**

Can you get insurance through an employer, spouse (if married), or parent (if under 26 years of age)?

- No, select all that apply:
  - I am unemployed
  - My employer does not offer health insurance
  - My spouse/parent is unemployed
  - My spouse/parent employer does not offer health insurance
- Yes, but I have not enrolled because:
  - I am not eligible for coverage. *You or your case manager must submit documentation of ineligibility.*
  - Coverage is insufficient. *You or your case manager must submit documentation of insufficient coverage.*
  - Coverage is unaffordable. *You or your case manager must submit documentation of unaffordability.*
  - I missed the open enrollment period. I will enroll during the next open enrollment period.
    - Company’s next open enrollment period: \_\_\_\_\_
    - Coverage following open enrollment begins: \_\_\_\_\_
  - 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. *Your case manager must submit written justification.*
  - Other. *You or your case manager must submit documentation of other reason(s), if any.*
- Yes, I am enrolled in health insurance through my:  Employer  Spouse  Parent
 

*You or your case manager must submit your health insurance summary of benefits or complete the following:*

Plan name: _____	Insurance Company: _____
Policy Holder Name: _____	Lab Copay/Coinsurance: _____
Pharmacy Deductible: _____	Medical Deductible: _____
Pharmacy Copay/Coinsurance for _____	Medical Copay/Coinsurance for _____
HIV Medications: _____	HIV Provider: _____
Out of Pocket Maximum: _____	HIV Provider In-Network? <input type="checkbox"/> Yes <input type="checkbox"/> No
Medications you take: _____	

## 12. Authorization for Release of Information

Not Applicable

I hereby authorize the Utah Department of Health, 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 2016 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 are 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 HIV 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: \_\_\_\_\_

Mail this form and all application documentation to: Box 142104, Salt Lake City, UT 84114-2104 or Fax to 801-536-0978.