

RYAN WHITE PART B PROGRAM APPLICATION FORM (September 2015)

ITEMS THAT MUST BE RETURNED WITH THIS FORM

One document from each of the following categories

If you are married you must return proof of income for your spouse also

Proof of Income:

- Three of your most recent pay stubs/earning statements **or**
- Social Security/Disability Letter **or**
- Supplemental Security Income (SSI) Letter **or**
- Unemployment Statement **or**
- Affidavit of Zero Income (*you can request this from your case manager*) **or**
- Schedule C from most recent Income Tax Forms (*if you are self-employed*)

Proof of Residency:

- Utility bill **or**
- Rent Agreement **or**
- Utah Driver License **or**
- Homeless Shelter Voucher **or**
- Bank statement **or**
- Utah ID **or**
- Federal IRS Tax Transcript **or**
- Pay Stub / Earning Statement

Proof of Insurance Denial (*you must get this from your case manager*)

- Medicaid Screening Form
- Proof of Employer Insurance Denial (*if applicable*)

Client Rights and Responsibilities Agreement

The Ryan White Part B Program will not accept incomplete applications.

Name: (Last, First, Middle Initial) _____ Birth Date: _____

Address: _____ City: _____ State: _____ ZIP Code: _____

Home Phone: _____ Cell Phone: _____ Social Security Number: _____ - _____ - _____ NA Refused

Are you currently taking HIV medications? Yes No E-mail: _____

Whether you file taxes or not, how many dependents do you claim (including self)? _____ Married: Yes No

Health Insurance, check all that apply: Marketplace (Private-Individual) Private-Employer COBRA Medicare

Medicaid, CHIP, Other Public (PCN) Military Health Care, VA, Tricare Indian Health Services (IHS)

No health insurance (includes self-pay or Ryan White) Other Plan: _____

Are you eligible for health insurance benefits under a domestic partner policy? Yes No

Have you ever served in the U.S. Armed Forces, Reserves, or National Guard? Yes No

Did you file taxes for 2014? Yes No

Housing/Living Arrangements: Stable/Permanent Temporary Unstable

Race (select one or more):

- White
- Black/African American
- Asian
- Native Hawaiian or other Pacific Islander
- American Indian or Alaska Native

Ethnicity:

- Hispanic/Latino(a)
- Non-Hispanic

Sex at Birth:

- Male
- Female

Current Gender:

- Male
- Female
- Transgender

If Transgender, what is your transgender subgroup:

- Male to Female
- Female to Male

Language Spoken in Home: _____

Race & Ethnicity Subgroups (select one or more):

- Hispanic
 - Mexican
 - Puerto Rican
 - Cuban
 - Other Hispanic
- Asian
 - Asian Indian
 - Chinese
 - Filipino
 - Japanese
- Korean
- Vietnamese
- Other Asian
- Native Hawaiian or other Pacific Islander
 - Native Hawaiian
 - Guamanian
 - Samoan
 - Other Pacific Islander
- These race and ethnicity subgroups do not apply to me.

INCOME AND ASSETS INFORMATION: Enter information below for all household members. If an asset is shared with someone not living in your household, enter the amount that belongs to you. Attach another sheet if more space is needed.

MONTHLY INCOME AMOUNT (also include spouse's income)

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

ASSETS AMOUNT (write value of all you own)

Checking AND Savings _____ Stocks/Bonds/CDs _____ Real Estate _____
Rental Property (that you rent to others) _____ Life Insurance/Annuities _____ Other Assets _____

I certify that the above information 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.

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 improvement, data reporting, 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.

Applicant's Signature: _____ Date: _____

PROVIDER INFORMATION Physician's Name: _____ Physician Phone Number: _____

Patient's Primary Diagnosis: _____ Case Manager's Name: _____

CD4 Count Date: ____/____/____ CD4 Count Value: _____ Viral Load Date: ____/____/____ Viral Load Value: _____

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

Date of HIV+ diagnosis: ____/____/____ (MM/DD/YYYY) If CDC-defined AIDS, date of AIDS diagnosis: ____/____/____ (MM/DD/YYYY)

Patient's Initial Risk Factor(s) for HIV infection (select one or more):

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

Physician's Signature: _____ Date: _____