Ryan White Part B Program Self-Attestation 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 □ Med D □ ADAP-M □ CM Only □ Supportive Service(s): _____
□ Request to Expedite by:____/____/____ _____

Applicant Information C1A MRN:_____ □ UAF Not Applicable
Legal Name (Last, First, Middle):_____Date of Birth:____/____/_____
Preferred Name:_____
Current Gender: □ Male □ Female □ Transgender (Male to Female) □ Transgender (Female to Male) □ Refused

Applicant Contact Information □ Do not contact me by mail The Program has my permission to text and/or e-mail me: □ Yes □ No
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:_____

HIV Status Are you currently taking HIV medications? □ Yes □ No

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.*

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.*

□ **NO CHANGE** since my most recent re-certification
I certify that my Utah residency / address, household income, assets, marital status, household size, health insurance, and housing / living arrangements have not changed.

□ **CHANGE** since my most recent re-certification

Utah residency / address change:	□ No	□ Yes
Household income change:	□ No	□ Yes
Asset change:	□ No	□ Yes
Marital status change:	□ No	□ Yes
Household size change:	□ No	□ Yes
Health insurance change:	□ No	□ Yes
Housing / living arrangement change:	□ No	□ Yes

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 B below ☐ Yes—complete section A below

A. 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:_____

Plan Name:_____

Health Insurance Company Name:_____ HIV Provider In-Network? ☐ Yes ☐ No

Policy Holder Name:_____ Access to HIV Medications? ☐ Yes ☐ No

Effective Date:_____

Out of Pocket Maximum:_____

**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.*

B. 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*

Address Change

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

Asset Change

# 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): _____

Household Size or Marital Status Change

Married: □ No □ Yes Spouse name, if also applying:_____ Household Size:_____

Housing Change □ Stable Permanent Housing □ Temporary Housing □ Unstable Housing

Household Income Change

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 <u>at least one</u> 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 <u>your</u> 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 <u>all other</u> 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.

☐ *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)			

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.

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:_____

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