Nevada Ryan White Parts ABCD
Common Guidance Document
Universal Application

Application Date: _____

☐ New Application (Never Enrolled in a Ryan White Program in Nevada before)

☐ Annual Update

☐ Six-Month Recertification (This form is not Required – please fill out 15-46 Self Attestation)

CONTACT INFORMATION

Legal Name: Last, First, Middle Initial			**Goes by or AKA:**	
Birth Date:	**SSN or Identifier:**		**Primary Language:**	
Home Address:		**City:**	**State:**	**Zip:**
Mail Address:		**City:**	**State:**	**Zip:**
1. Phone – include area code:	**Type:**			
2. Phone – include area code:	**Type:**			
e-mail:				

May we contact you by mail? ☐ Yes ☐ No

Should mail be confidential? ☐ Yes ☐ No

May we contact you by phone? ☐ Yes ☐ No

Message OKAY? ☐ Yes ☐ No

With the Home Address provided, do you rent, own, live with family on a permanent basis, use HOPWA funded housing assistance, Section 8 assistance, the HOME Investment Partnership Program, live in Public Housing, Shelter Plus Care, Supportive Housing Program, or Moderate Rehabilitation Program for SRO Dwellings?

☐ **Yes**

☐ **No, Please fill out Form 15-44 Non-Stable Housing Declaration**

EMERGENCY CONTACT

Name:	**1. Phone – include area code:**	**2. Phone – include area code:**	
Address:	**City:**	**State:**	**Zip:**
Notes:			

DEMOGRAPHICS

Current Gender Identity: ☐ Male ☐ Female ☐ Unknown

Sex at birth: ☐ Male ☐ Female

☐ Transgender Male-to-Female (MTF) ☐ Transgender Female-to-Male (FTM)

☐ Transgender (trans*, gender queer, gender non-conforming)

Ethnicity: ☐ Non-Hispanic/Latino

☐ Hispanic/Latino, (*if checked, choose an option below)*

- ☐ Mexican, Mexican American, Chicano/a
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Another Hispanic, Latino/a or Spanish origin

Race: ☐ White ☐ Black ☐ American Indian/Alaskan Native

☐ Native Hawaiian/Pacific Islander ☐ Asian

- ☐ Native Hawaiian
- ☐ Guamanian/Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander

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

Relationship Status: ☐ Single ☐ Married ☐ Domestic Partnership ☐ Unmarried Couple ☐ Divorced ☐ Separated ☐ Widowed ☐ Unknown ☐ Other:

Education Level: ☐ No High School ☐ Some High School ☐ High School Diploma/GED ☐ Trade/Technical School ☐ Some College ☐ College Degree ☐ Graduate Degree

Are you a veteran? ☐ Yes ☐ No

Special Needs:

HIV/AIDS STATUS AND DIAGNOSIS INFORMATION

HIV/AIDS Status:

☐ HIV Negative (Affected) ☐ HIV Positive

☐ CDC Defined AIDS ☐ HIV Indeterminate (infants <2 years old) ☐ HIV Positive (AIDS status unknown)

Date of First HIV+ Diagnosis:	☐ **Estimated?**
Date of First AIDS Diagnosis:	☐ **Estimated?**

How do you believe you contracted HIV?

☐ Male to Male sexual contact
☐ Injection Drug Use
☐ Heterosexual Contact
☐ Hemophilia/Coagulation Disorder
☐ Recipient of transfusion of blood, blood components, or tissue
☐ Perinatal Transmission
☐ Undetermined/Unknown, risk not reported or identified
☐ Other, please specify: _____

Basic Medical

Medical Providers

Primary Care Physician Name:
HIV Specialist Name:

Current Prescribed Medications

ART Drug	Prescribed by	Start Date	Dosage

Ryan White and Other Service Needs

Which Ryan White Services do you need?

☐ Medical case management	☐ Dental care	☐ Vision
☐ Housing assistance	☐ Medical nutrition therapy (dietician)	☐ Treatment adherence
☐ Assistance with food and meals	☐ Mental health therapy	☐ Psychosocial support
☐ Substance use therapy	☐ Support group	☐ Transportation assistance
☐ Health education/prevention	☐ Medical care	☐ Other: _____

Client Affidavit

Under penalty of perjury, I swear or affirm that all of the information supplied by me in this affidavit is complete, true and correct, and the State of Nevada may rely on this information. I, therefore, release all records to the State of Nevada to perform a verification of all application information provided. If I deliberately misrepresent information on this application my benefits will be terminated immediately and I may be prosecuted under applicable State & Federal Statutes, including but not limited to criminal charges, fines and property liens. I understand that I may be held personally liable for the cost of all drugs, core medical and support services if I deliberately falsified any documents or statements on this application.

It is my responsibility to renew my eligibility within 6 months of this application.

Name (Please Print)	Signature	Date

I had assistance in understanding and completing this application by

Name (Please Print)	Signature	Date