Application for Ryan White Part B Services

(Please Print Legibly)

Application Date: _____

☐ New Application
☐ Update/Recertification
☐ Re-open after break in coverage

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:**	**May we contact you by mail?**	☐ **Yes**	☐ **No**
2. Phone – include area code:	**Type:**	**Should mail be confidential?**	☐ **Yes**	☐ **No**
e-mail:		**May we contact you by phone?**	☐ **Yes**	☐ **No**
		Message OKAY?	☐ **Yes**	☐ **No**

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:

LIVING SITUATION

Current Living Situation: **Living Situation Since:** _____

- ☐ Homeless from the street
- ☐ Homeless from emergency shelter
- ☐ Transitional housing
- ☐ Psychiatric facility
- ☐ Substance abuse treatment facility
- ☐ Hospital or other medical facility
- ☐ Jail/ Prison
- ☐ Rented Room
- ☐ Domestic violence situation
- ☐ Living w/ relatives or friend
- ☐ Rental Housing
- ☐ Own home
- ☐ Board care or assisted living
- ☐ Refused to answer
- ☐ Unknown
- ☐ Other

If you rent or own, do you have a signed lease, title, or tax receipt? ☐ Yes ☐ No

FAMILY/HOUSEHOLD AND FINANCIAL INFORMATION

Family/Household Information

Please list information on spouse, children, and any dependents in the table below (must be completed to claim dependents).

Name	Relationship	Age

Total Number of People in Family/Household (including yourself): _____

Is anyone in your household HIV+ and in need of Ryan White services? If so, please discuss this with the eligibility specialist at this time so that they can be referred to Ryan White services appropriately.

Financial Information

1. Are you employed? ☐ Yes ☐ No
2. If you are married/registered domestic partnership, is your spouse/partner employed? ☐ Yes ☐ No
3. Do you receive unearned income? (Social Security, child support, etc.) ☐ Yes ☐ No
4. Do you receive any public assistance? (Social Security, child support, etc.) ☐ Yes ☐ No
5. If NO, what is your source of income?

If you have no means of financial self-support, you must complete the Verification of No Income form (15-45) and Dependent Support Form (15-48).

MODIFIED ADJUSTED GROSS INCOME (MAGI) CALCULATION

Use the tables below to estimate client's MAGI for the most recent month. For income losses, enter negative $ amounts. Items with an asterisk do not count towards total income. Include these items in both tables so they cancel out.

MAGI Income Sources – Total Monthly $ Amount for All Household Members			
***Supplemental Income from Social Security (SSI)**		Pensions & Annuities (Veteran/Employer Based Pensions, Retirement)	
***Child support received, workers comp, monetary gifts**		Retirement Security (SSA) Income from Social	
Other income (Jury Duty Pay)		IRA Distributions - Taxable amount	
Disability Income from Social Security (SSDI)		Capital Gain/Loss	
Wages, Salaries, tips, etc.		Other Gains/Losses	
Unemployment Income		Business Income/Loss	
Alimony or other Spousal Support Received		Farm income or loss	
Gambling Winnings		Rental real estate partnerships, S Corporations, Trusts, etc.	
Taxable refunds of State/Local Income Taxes			
Total Column 1 =		**Total Column 2 =**	
Total Column 1 + Total Column 2 = Gross Income =			

Non MAGI Income Sources – Total Monthly $ Amount for All Household Members (needed to calculate adjustments)			
***Supplemental Income from Social Security (SSI)**		Court Ordered Child Support	
		Government Tax Liens	
***Child support received, workers comp, monetary gifts**		Penalty on Early Withdrawal of Savings	
Business Expenses		Alimony /court ordered spousal support paid	
Educator Expenses		IRA deduction	
Health Savings Account		Student Loan Interest Deduction	
Moving Expenses		Tuition and Fees	
Self-Employed SEP, SIMPLE plans		Domestic Production Activities	
Self-Employed Health Insurance		Court Costs/Probation Fees	
Health Insurance Costs and Co-Pays		Deductible Part of Self Employment Tax	
Total Column 1 =		**Total Column 2 =**	
Total Column 1 + Total Column 2 = Total Income Adjustments =			

Monthly Modified Adjusted Gross Income	=	**Gross Income**	−	**Total Income Adjustments**	=	

Annual Income	=	**Monthly MAGI**	×	**Months per Year** **12**	=	

Use Annual Income to Determine Federal Poverty Level

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?**	**County:**	**State:**
Date of First AIDS Diagnosis:	☐ **Estimated?**	**County:**	**State:**

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: _____

Health Care Coverage

Do you have some type of health care coverage – public or private?

☐ **YES.** I have the following types of health care coverage (please check all that apply):

☐ Private insurance I enrolled in as an individual
☐ Private insurance through work
☐ Medicare Part A/B
☐ Medicare Part D
☐ Medicaid
☐ Indian Health Service (IHS) benefits
☐ Veteran's Administration (VA), Tricare, other military health care
☐ Other, please specify: _____

Does you need assistance to help pay for your health insurance? ☐ Yes ☐ No

Medical Insurance Details

Carrier	Policy #	Start / End Date	Monthly Premium Amount	Other notes

☐ **NO**. I do not have health care coverage at this time.

You must make every effort to have and maintain health care coverage. Your eligibility specialist/case manager will work with you to create an enrollment plan. If you do not enroll in a health plan, you may have to pay a fee that increases every year.

If you are undocumented, you will not qualify for health care coverage and do not need to apply for health care coverage through Nevada Health Link.

If you are exempt from enrolling in Health Care Coverage, you will need to provide a certificate of exemption.

BASIC MEDICAL

Medical Providers

Primary Care Physician Name:	Phone:	Last Visit Date:
HIV Specialist Name:	Phone:	Last Visit Date:

CD4 & Viral Loads

CD4 Date	CD4 Count	CD4%	Viral Load Date	< = >	Value	Test Type	Log

Pharmacies

Pharmacy Name	Address	Phone

Anti-Retroviral Drugs

ART Drug	Prescribed by	Start Date	End Date	Dosage

RYAN WHITE AND OTHER SERVICE NEEDS

Which Ryan White Services do you need?

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