## Application for Ryan White Part B Services (Please Print Legibly)



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

<b>CONTACT INFORMAT</b>	ION							
Legal Name: Last, First,	Middle Initial			Goes by	or AKA:			
Birth Date:	SSN or Identifie	SSN or Identifier:		Primary	Primary Language:			
Home Address:			City:		State:	Zip:		
Mail Address: City		City:		State:	Zip:			
1. Phone – include area	code:	Type: May we con		tact you by	mail?	I	□ Yes	🗆 No
2. Phone – include area	code:	Туре:	Should mail be confidential?			🗆 Yes	🗆 No	
e-mail:		L	May we con	tact you by	phone?		□ Yes	🗆 No
			Message OK	AY?			🗆 Yes	🗆 No
EMERGENCY CONTAC	ст							

Name:	1. Phone –	include area code:	2. Phone – inclu	ıde area code:
Address:		City:	State:	Zip:
Notes:	I			
DEMOGRAPHICS				
Current Gender Identity: 🗆 Male 🛛 Female	🗆 Unknown		Sex at birth:	🗆 Male 🛛 Female
Transgender Male-to-Female (MTF)	ler Female-to	-Male (FTM)		
□ Transgender (trans*, gender queer, gender non-con	forming)			
Ethnicity: 🗌 Non-Hispanic/Latino		Race: 🗆 White 🗆 Bl	ack 🗌 American	Indian/Alaskan Native
<ul> <li>Hispanic/Latino, (<i>if checked, choose an op</i></li> <li>Mexican, Mexican American, Chicano</li> <li>Puerto Rican</li> <li>Cuban</li> <li>Another Hispanic, Latino/a or Spanish</li> </ul>	o/a	<ul> <li>Native Hawaiian/P</li> <li>Native Hawaiian</li> <li>Guamanian/Chai</li> <li>Samoan</li> <li>Other Pacific Isl</li> </ul>	n amorro	<ul> <li>Asian</li> <li>Asian Indian</li> <li>Chinese</li> <li>Filipino</li> <li>Japanese</li> <li>Korean</li> <li>Vietnamese</li> <li>Other Asian</li> </ul>
Relationship Status:       Single       Married       Domes         Separated       Widow	stic Partnersh ved	ip 🛛 Unmarried Couple	Divorce     Divorce     Other:	t
Education Level:			□ College Degree	Graduate Degree
Are you a veteran?				

#### LIVING SITUATION

Current Living Situation:	Living Situation	Since:
$\square$ Homeless from the street	$\square$ Homeless from emergency shelter	Transitional housing
Psychiatric facility	$\square$ Substance abuse treatment facility	$\Box$ Hospital or other medical facility
Jail/ Prison	🗆 Rented Room	$\Box$ Domestic violence situation
$\square$ Living w/ relatives or friend	Rental Housing	🗆 Own home
$\square$ Board care or assisted living	Refused to answer	🗆 Unknown
🗌 Other		
If you rent or own, do you have a signe	ed lease, title, or tax receipt? $\Box$ Yes $\Box$	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?	$\Box$ Yes	🗆 No
3. Do you receive unearned income? (Social Security, child support, etc.)	$\Box$ Yes	🗆 No
4. Do you receive any public assistance? (Social Security, child support, etc.)	$\Box$ Yes	🗆 No
5. If NO, what is your source of income?		

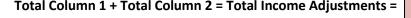
# If you have no means of financial self-support, you must complete the Verification of No Income form (15-45) and Dependent Support Form (15-48).

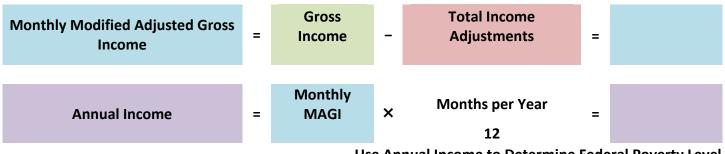
#### MODIFIED ADJUSTED GROSS INCOME (MAGI) CALCULATION

Use the tables below to estimate client's MAGI for the most recent <u>month</u>. 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				
		Pensions & Annuities		
*Supplemental Income from Social Security (SSI)		(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,		
Taxable refunds of State/Local Income Taxes		S Corporations, Trusts, etc.		
Total Column 1 = Total Column 2 =				
Total Column 1 + Total Column 2 = Gross Income =				

	Ionthly \$ Amount for All Household Members alculate adjustments)	
	Court Ordered Child Support	
*Supplemental Income from Social Security (SSI)	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 =	





Use Annual Income to Determine Federal Poverty Level

#### **HIV/AIDS STATUS AND DIAGNOSIS INFORMATION**

#### **HIV/AIDS Status:** □ HIV Negative (Affected) □ CDC Defined AIDS

□ HIV Indeterminate (infants <2 years old)

□ HIV Positive □ 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?

<b>YES.</b> I have the following types of healt	h care coverage (please ch	neck all that apply):
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$\Box$ Private insurance I enrolled in as an individual	□ Medicaid
Private insurance through work	$\Box$ Indian Health Service (IHS) benefits

□ Medicare Part A/B

□ Medicare Part D

□ Veteran's Administration (VA), Tricare, other military health care  $\Box$  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

 $\Box$  Assistance with food and meals

Substance use therapy

- □ Health education/prevention
- Dental care
- □ Medical nutrition therapy (dietician)

□ Mental health therapy

- Support group
- $\Box$  Medical care

 $\Box$  Vision

□ Treatment adherence

□ Psychosocial support

□ Transportation assistance

 $\Box$  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