ARIZONA RYAN WHITE AND ADAP CHANGE FORM

If income has changed since last application, please request one months' worth of income statements.
If insurance has changed since then, please include copies of all current insurance cards.

APPLICANT INFORMATION

Last Name	First Name	Date of Birth
		__ __/ __ __/__ __ __ __

☐ CHANGE IN ADDRESS & PHONE

Home Address ☐Homeless	Apt/Suite#	City	State	Zip Code	Mail Ok?
					☐Yes ☐No
Mailing Address *(if different than home)*	**Apt/Suite#**	**City**	**State**	**Zip Code**	**Mail Ok?**
					☐Yes ☐No

Initial: _______ *I understand that if I do not provide a mailing address I will* ***NOT*** *receive eligibility notices or mail from my Ryan White service providers. If shipping address is provided below, medications (Rx)* ***ONLY*** *will be shipped to that address.*

Rx Shipping Address *(if different than mailing)*	Apt/Suite#	City	State	Zip Code

Primary Phone #	May we leave a message?	Secondary Phone #	May we leave a message?
( ) -	☐Yes ☐No	( ) -	☐Yes ☐No

☐ CHANGE IN HOUSEHOLD SIZE OR INCOME

Household Size	Monthly Gross Income	Annual Gross Income

☐ CHANGE IN HEALTH COVERAGE PAYER OR MEDICAL PROVIDER

☐AHCCCS
☐ALTCS
☐MEDICARE
☐A ☐B ☐D ☐Full LIS
☐Advantage Plan

☐Private – Employer:____________________
☐Private – Individual:____________________
☐FFM Plan:____________________
☐Other:____________________

☐Veterans Affairs
☐Indian Health Service
☐Federal Emergency Service
☐No Insurance
MEDICAL PROVIDER:
____

☐ CHANGE IN NAME (client required to provide documentation of change)

Name Currently in CAREWare	New Name to be entered in CAREWare

☐ CHANGE IN VITAL STATUS

Deceased Date	Informant

To be completed by a representative of a Ryan White Provider Agency or ADAP

Please mark all services that this update needs to be sent to:

☐Update RWPA ☐Update RWPB ☐Update ADAP

______________________________ ______________________________
Signature of Provider Representative Date

______________________________ ______________________________
Printed Name of Provider Representative Provider Agency Name

FOR OFFICE USE ONLY

Date Received:_____-_____-_____/_____ Assigned Reviewer: ________________________

Date Reviewed:_____-_____-_____/_____ ☐Completed ☐Pre-Approved ☐Incomplete

Missing Documents Needed: $$ RES AHCCCS Det BVF Other:______________________

Missing Documents Received:_____-_____-_____/_____

___-___-___/___ **Date Complete/Pre-App** ___-___-___/___ **Date Scanned** ___-___-___/___ **Date Entered in RWISE**