Arizona Ryan White and ADAP Application

APPLICANT INFORMATION

Legal Last Name	Legal First Name	MI

Birth date (month/day/year)	AKA (including maiden & nicknames)

Self-Identified Gender	Gender Assigned At Birth
☐ Male ☐ Transgender – Male to Female ☐ Female ☐ Transgender – Female to Male	☐ Male ☐ Female

Language Preference	Social Security Number (SSN)*
☐ English ☐ Spanish ☐ Other: ____________________	

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

Email Address	OK to E-Mail?
	☐Yes ☐No

Primary Phone #	Secondary Phone #
______________________________	______________________________
Type: ☐Home ☐Cell ☐Work ☐Other	**Type:** ☐Home ☐Cell ☐Work ☐Other
OK to leave messages? ☐Yes ☐No	**OK to leave messages?** ☐Yes ☐No

Alternative Contact Person	Relationship	Phone Number	Aware of Status?
			☐Yes ☐No
Ryan White Case Manager Name	**Agency**	**Phone Number**	**Contact instead of client?**
			☐Yes ☐No
Doctor Name	**Clinic Name**	**Phone Number**	**Fax Number**

**SSN information is not used for eligibility determination. It is used to verify income, AHCCCS eligibility, and/or verify Medicare coverage.*

FOR OFFICE USE ONLY

Application Type: ☐Initial/New ☐Birthday Renewal ☐Birthday Re-Enrollment

Applicant is applying for: ☐RWPA ☐RWPB ☐RWPC ☐ADAP ☐Dental

Date Received:___________ ☐Logged In/____________ Assigned Reviewer: ____________________

Date Reviewed:___________ ☐Complete ☐Pre-Approved ☐Incomplete

FOR PRE-APPROVED APPLICATIONS

Pending Documents: DX $$ Labs AHCCCS Determination BVF Other: ____________________

☐BVF Distributed______________ MPP/Lab Request Sent to:________________on______________

Client Advised of Status & Add. Info Needed on_______-____-________ Type: E-Mail VM TC FF

FOR INCOMPLETE APPLICATIONS

Missing Documents: DX $$ RES Other: ____

Reminder Contact Date:______________ Type: E-Mail VM TC FF

-Form to be Sent:______________ Sent:______________ To be Closed on:______________

Missing Documents Received:_____________

Date Received	Date Complete	Date Sent to ADAP	Date Entered	Date Attached

RESIDENCY

Please provide **ONE** of the following residency documents issued within the allowable timeframes.

- The documents must be dated and include the client's name and home address (no P.O. Boxes).
- **Attach copies to this application.**

RESIDENCY DOCUMENTS (check **ONE** and attach a copy of documents)
☐ Annual income award letter from a government agency or pension - *issued for the current year*
☐ Mortgage, lease/rental agreement, or non-permanent housing letter – *most recent, not expired*
☐ Any Document or mail with the client's name and address – *issued within the last 60 days* Examples include: DES, Medicare, utility bill, bank statement, other bills, check stubs
☐ Driver's License or AZ ID Card – *issued within the last year*
☐ Tribal enrollment, US Immigration Identification Card – *most recent, not expired*
☐ Proof of current Arizona Health Care Cost Containment System (AHCCCS) Enrollment
☐ Federal or state tax return showing Arizona residency - *filed within the last year*
☐ Attestations of residency or homelessness from a social service provider, medical provider, or family/friend- signed within 30 days (use one of the attestations below or provide a signed and dated written statement with the client's name, date of birth, and address)

Residency Attestation

May be completed by Medical Provider, Case Manager, Ryan White Eligibility Specialist, Family or Friend

I affirm to the best of my knowledge:______________________________

Lives at: ____

____________________________	____________________________
Printed Name	Relationship to client
____________________________	____________________________
Signature	Date

Attestation of Homelessness

Agency Use Only: May only be completed by a social service or medical provider.

I affirm to the best of my knowledge:______________________________ is homeless at this time.

____________________________	____________________________
Staff Member Name	Name of Provider Agency
____________________________	____________________________
Staff Member Signature	Date

INCOME AND HOUSEHOLD SIZE

Please provide ONE CONSECUTIVE MONTH of income source documents.

- Documents must be issued within the allowable timeframes.
- **Attach copies to this application.**

INCOME SOURCE DOCUMENTS (check **ALL** that apply and attach copies)
☐ Annual award letter – *Social Security, VA, annual pension, etc. ; Current year & valid*
☐ Other award letter – *TANF, Unemployment, etc.; Current period & valid*
☐ 1 month of check stubs – If no check stub received, may submit employer statement.
☐ Self-employment records – only *use the Self Employment/Non-Traditional Income Worksheet if other documents not available*
☐ Current federal tax returns – *filed within the last year*
☐ Proof of current Arizona Health Care Cost Containment System (AHCCCS) enrollment
☐ Other income source not listed above –*requires Certification of income and/or Support*
☐ No Income – *requires Certification of Income and/or Support*

In the table below, list every family member residing within your household and/or can be claimed as an exemption on your federal tax return (i.e. legal spouse, biological/adopted children, individual you provide more than 50% support for)

HOUSEHOLD INFORMATION TABLE					
Applicant or Family Member Name	**Relationship**	**Monthly Gross Income**	**Source**	**Over age 18?**	**Claimed on Taxes**
Applicant	**Self**			☐ Yes ☐No	☐ Yes ☐No
				☐ Yes ☐No	☐ Yes ☐No
				☐ Yes ☐No	☐ Yes ☐No
				☐ Yes ☐No	☐ Yes ☐No
				☐ Yes ☐No	☐ Yes ☐No
Household Size	**Total Monthly Gross Income**		**Total Annual Gross Income**		

EMPLOYMENT STATUS FOR APPLICANT/ADULT IN THE FAMILY UNIT

☐ Working: ______hours per week
☐ Seasonal/Temporary
☐ Full/Part-time college student
☐ Social Security Income (SS)
☐ Social Security Disability Insurance (SSDI)
☐ Supplemental Security Income (SSI)
☐ Unemployed/No Income
☐ Unemployment Benefits
☐ Self-Employed
☐ Other: ____________________
____

CERTIFICATE OF INCOME

I confirm that I am supporting myself in the following manner: (check and complete all that apply)

☐ I am homeless or living in a shelter.

☐ I am receiving assistance for obtaining food, water, housing, and clothing from:________________________________
Please attach a letter of support from this person or have this person complete the 'Certificate of Support' below.

☐ Other:____

I attest that, to the best of my knowledge and belief that the information submitted is accurate and complete.

CERTIFICATE OF SUPPORT

I_________________________am providing support to______________________________for him/her to obtainfood, water, housing, and clothing.

______________________________________ ____
Signature Date

MEDICAL/ DENTAL INSURANCE/ OTHER PAYOR

If you have medical coverage, please attach copies of ALL medical/dental/prescription cards.

You will be required to provide proof of denial for health insurance coverage if it appears you may be eligible.

HEALTH INSURANCE SCREENING

ARIZONA MEDICAID – AHCCCS

What is your AHCCCS status?

☐ Enrolled – Plan Name:______________

Effective date:_____/_____/_____

☐ Pending – Date applied:_____/_____/_____

☐ Denied Date:_____/_____/_____

☐ FES Eligible

Not Applicable ☐ Over Income ☐Other ______________

FEDERALLY FACILITATED MARKETPLACE (FFM) INSURANCE

What is your FFM status?

☐ Enrolled – Plan Name:______________

Effective date:_____/_____/_____

☐ Pending – Date applied:_____/_____/_____

☐ Pending Open Enrollment - Year______

☐ No Special Enrollment Period (SEP)

☐ Not Applicable ☐Categorically Ineligible ☐Other Coverage

MEDICARE

What is your Medicare status?

☐ Enrolled – Effective Date_____/_____/_____

☐ A ☐B ☐D Plan Name:______________

☐ Medicare Advantage ☐Medicare Supplemental

Plan Name______________________

Will you be eligible for Medicare in the next 12 Months?

☐ Yes ☐No Effective Date :_____/_____/_____

Have you ever been enrolled in Medicare but are not now?

☐ Yes ☐No Dates of coverage__________to__________

Not applicable ☐<65 ☐Not Disabled ☐Categorically Ineligible

If you are enrolled in Medicare, what is your Extra-Help/Low-Income Subsidy?

☐ Enrolled -_____% Subsidy ☐Pending - Date applied:____/____/____ ☐Denied – Date:_____/_____/_____

OTHER GOVERNMENTAL HEALTH INSURANCE PROGRAMS

Are you eligible for or do you receive health services from Veterans Affairs? ☐Yes ☐No

Are you eligible for or do you receive health services from Indian Health Service? ☐Yes ☐No

PRIVATE OR EMPLOYER HEALTH INSURANCE

☐Enrolled Insurance Provider Plan Name:______________________

I get insurance from ☐My Employer ☐Spouse/Domestic Partner or Parent ☐Private, Individual Plan ☐COBRA

Are prescription drugs covered? ☐Yes ☐No

☐I am not enrolled but, can get it from:☐My Employer ☐Spouse/Domestic Partner or Parent ☐Private, Individual Plan ☐COBRA

☐I am not eligible to get insurance through my employer, Spouse/Domestic Partner, Parent, or COBRA

If you and/or your spouse are employed but you do not have employer offered insurance coverage, please have the employer complete the Benefit Verification Form.

DENTAL INSURANCE SCREENING

Are you eligible for, or enrolled in a dental insurance program other than Ryan White? ☐Yes ☐No Plan Name: __________

Have you been denied dental insurance by a program you otherwise are eligible for? ☐Yes ☐No

REFERRAL NEEDS

REFERRAL NEEDS	
Have you seen your health practitioner in the past 6 months?	☐ Yes ☐ No
Have you had lab work done in the past 6 months?	☐ Yes ☐ No
Are you taking HIV medications?	☐ Yes ☐ No
Is your housing or living situation stable?	☐ Yes ☐ No
Is your ability to provide your daily living needs stable?	☐ Yes ☐ No
Do you have transportation resources to meet your needs?	☐ Yes ☐ No
Do you have issues with stress and/or depression in your life?	☐ Yes ☐ No
Do you have addictions or substance abuse issues in your life?	☐ Yes ☐ No
Do you want a referral for help with any of the above issues?	☐ Yes ☐ No

RWPA/B/ADAP/DENTAL ATTESTATION and RELEASE OF INFORMATION

Please review each statement and sign below:

- I may qualify for Ryan White funded services even if I have other insurance.
- I will report any changes to my household income, my address, and other things that may affect my services. If I do not, I may not be eligible or may have to re-pay the Ryan White Program.
- At least every six months, I will complete the required eligibility process or I may not remain in the program.
- The information provided in this application is accurate and complete to the best of my knowledge. Any unreported items may prevent, delay a decision about my eligibility, or result in loss of eligibility.
- I acknowledge that I have received a copy of the Ryan White Program Notice of Privacy Practices, Client Rights/Responsibilities, and Client Grievance Policy, as applicable.
- My enrollment may be terminated if I exhibit violent or threatening behavior to any Ryan White/ADAP Program representatives.

I, (Client Name), authorize Care Directions, Chicanos Por La Causa, Ebony House, Valleywise Health, Maricopa County Department of Public Health, Phoenix Indian Medical Center, Southwest Center for HIV/AIDS, Sun Life, Terros Health, RipplePHX, Ryan White HIV/AIDS Program Grantees and/or Contractors, all Ryan White Part B Grantees and/or Contractors, all Rapid Start Network Community Partner Organizations, SAAF/Delta Dental and ADAP to disclose my protected health information (PHI) and other information from my records to any Ryan White HIV/AIDS Program (RWHAP) Grantee or Contractor operating in the State of Arizona.

The purpose of the disclosure is to permit RWHAP Grantees and/or Contractors and Partners to exchange my PHI or other information from my records toRyan White Contractors and Grantees for the purposes of:

- Continuity of care, treatment, payment, and health care operations, including eligibility, demographic, health insurance premium and copay payment, emergency treatment, and/or payments to Contractors or other statistical reporting information;
- Mandated reporting, including client-level data reporting;
- Disclosures required by law;
- Legal process and proceedings;
- Oversight including quality assurance reviews and audits of Ryan White-funded services provided;
- Disclosure to a Medical Examiner;
- Disclosure of notifiable public health conditions; and
- Inclusion in shared data systems for demographic, eligibility, and other statistical reporting;
- If in the course of providing services to a client, a RWHAP Grantee or Contractor identifies information that could be harmful to the client or the public; the provider may report that information to the appropriate authorities.

  If required for the purposes listed above, I authorize the disclosure of the following information until the end of the month, one (1) year from the date of my signature below:
    - HIV/AIDS and other communicable disease information, including HIV Counseling and Testing;
    - Behavioral, Mental Health or Psychiatric treatment information; and/or
    - Substance abuse treatment information.

Unless I revoke this authorization earlier, it will expire at the end of the month, one (1) year from the date of my signature below. I also understand that my revocation will not apply to information that has already been released in response to this release. To revoke this authorization, I must submit a written request to the following agencies:

Central Eligibility Office, Care Directions, 1366 E. Thomas Road, Suite 203, Phoenix, AZ 85014 ceoffice@aaaphx.org OR
Arizona Department Health Services, 150 N. 18th Ave. Suite 280, Phoenix, AZ. 85007 careandservices@azdhs.gov

By signing this Release of Information, I release all Ryan White Grantees and Contractors, their employees, officers, directors, medical staff, and agents from any legal responsibility or liability for the disclosure of information to the extent indicated and authorized in this Release. I also understand that Ryan White Grantees and Contractors will maintain the confidentiality of my disclosed PHI or other information, and that they will use my PHI or other information only for the purposes listed above.

______________________________	______________________________	________________
Printed Name	Signature	Date
______________________________	______________________________	
Signature of Legal Representative	Relationship to Client	

SUPPORT DOCUMENT GUIDE

REQUIRED SUPPORT DOCUMENTS – ALL APPLICANTS

- ☐ Proof of Residency – see page 2 for accepted documents
- ☐ Proof of Income – see page 3 for accepted documents
  - ☐ Letter of Support – *if applicable*

    If you signed the Certificate of Income and/or Support, the person helping you must provide a letter of support.
- ☐ Proof of Healthcare Coverage (as applicable)
  - ☐ AHCCCS card, AHCCCS approval notification, AHCCCS enrollment documentation
  - ☐ Medicare card, Medicare enrollment letter
  - ☐ Private health insurance card
- ☐ AHCCCS Denial – dated within the calendar year (REQUIRED only for clients with income ≤ 150% FPL)
  - Denial due to failure to submit documentation is not accepted.
  - Enrollment in Federal Emergency Services (FES) is considered an AHCCCS denial.

  If living in Maricopa or Pinal county, applicable denials will be generated through the Central Eligibility Office.
- ☐ Viral Load Lab Results (Copy of Viral Load Lab report drawn within the last 6 months or Medical Provider Page (MPP) if unavailable through HIV Surveillance matching only)
- ☐ Income Template (Internal Use Only)

REQUIRED SUPPORTING DOCUMENTS – ADAP/RWPB

- ☐ Medicare Extra Help/LIS Award or Denial Letter dated within the last 2 calendar years (REQUIRED only for clients with income ≤ 175% FPL)
- ☐ If you are or were enrolled in the FFM and receive premium assistance from ADAP, attach a copy of your federal taxes from the prior year

REQUIRED SUPPORTING DOCUMENTS – New Applicants Only

- ☐ New Applicant Addendum
- ☐ Proof of Diagnosis

ADDITIONAL SUPPORTING DOCUMENTS –Required under certain circumstances

- ☐ Benefit Verification Form
- ☐ 90 Day Medical Provider Override Form
- ☐ Affidavit of Understanding for individuals enrolled in a Federally Facilitated Marketplace plan
- ☐ Ryan White Self-Employment/Non-Traditional Worksheet
- ☐ Statement of Fact