Office use only: URN: _____

Date received: _____Date processed: _____

Nebraska Ryan White Program Recertification

Applicant Information

Full Name

Mailing Street Address | City | State | Zip Code

Telephone Number | Email Address

☐ I do not have a Nebraska AIDS Project (NAP) Case Manager.

☐ My NAP Case Manager's name is:_____

Income

☐ My household income has *not* changed since the last time I completed a Ryan White Program application. ***(Skip to Insurance and Lab Results)***

☐ My household income *has* changed since the last time I completed a Ryan White Program application.

List monthly gross (before taxes and deductions) income information for yourself and any other household members for whom you are legally responsible. **Attach proof of income.**
Total number of persons in your household for whom you are legally responsible for: _____

Full Name	Relationship	Birth Date	Income Source	Monthly Gross Amount
Applicant	Self			$
				$
				Total: $

☐ I do not have an income. ☐ My spouse does not have an income.
☐ I am paid in cash. ☐ My spouse is paid in cash.

Checking the no income and/or paid in cash box and signing this form serves as verification of no income and/or paid in cash for Nebraska Ryan White Program recertification purposes.

If you do not have an income, then explain how your basic needs (shelter, food, etc) are met?
_____

Insurance and Lab Results

☐ Private-Employer based ☐ Private-Individual ☐ Medicaid ☐ Medicare ☐ TRICARE
☐ Affordable Care Act *(circle source: Nebraska ADAP or Iowa ADAP or Self-purchase)*
☐ No Insurance/Uninsured ☐ Indian Health Services (IHS) ☐ Other: _____.

Non-UNMC Patients: *Provide your recent CD4 count and Viral Load lab results. Do not leave this section blank. If you don't know your lab results, then contact your medical provider for this information.*
CD4 Count: _____ Viral Load: _____

CD4 Count Date: _____ Viral Load Date: _____

TURN OVER AND SIGN

Nebraska Ryan White Programs Consent

I, _____, understand the following:
(Print name)

1. The standards for eligibility and participation in the Ryan White CARE Act funded programs are the same for everyone regardless of race, color, national origin, age, disability or gender**.**

2. This program involves the receipt of federal funds. The Nebraska Department of Health and Human Services Ryan White Part B Program/AIDS Drug Assistance Program, the University of Nebraska Medical Center Ryan White Part C and D Programs, and the Western Community Health Resources Panhandle Ryan White
Part C Program reserve the right to limit or deny services in order to adhere to the budgetary limitations of the Program.

3. I hereby grant permission for the exchange of information amongst the Program Coordinators, Nebraska AIDS Project Case Managers, care providers, the Nebraska Department of Health and Human Services, the University of Nebraska Medical Center, the Western Community Health Resources and/or the Iowa Ryan White Program regarding this application and all items related to the application, as it relates to Ryan White CARE Act funded services. I understand that information will not be released to any person or entity not included in this agreement without my consent.

4. I hereby give authorization to allow the release of information including but not limited to financial billing information as it pertains to my care to the Nebraska Department of Health and Human Services, Ryan White Part B Program, AIDS Drug Assistance Program, The University of Nebraska Medical Center Ryan White Part C and D Programs, and/or the Western Community Health Resources Ryan White Part C Program. I understand this information will be used to evaluate my care and provide statistical data pertaining to program evaluation and quality assurance activities.

5. I agree to promptly notify the applicable Program Coordinator/Case Manager/Provider if I have any life changing events that may impact my eligibility for Ryan White CARE Act funded services. Including but not limited to a change in my address, living situation, physician/care provider, Medicaid/Medicare/private insurance status, residency/immigrant status, financial status, I understand that I must apply every six months for ADAP and annually for Ryan White Part B, Part C and Part D program services to determine my eligibility.

6. I certify all the statements made on all parts of this registration are true and complete to the best of my knowledge. I realize that falsification of information may subject me to immediate ineligibility of participation for Ryan White services.

_____

Applicant signature Date

_____

Case manager signature (if assisted with application) Date