NEBRASKA RYAN WHITE PROGRAM APPLICATION

(PLEASE PRINT CLEARLY)

Today's Date: _____/_____/_____

Please check the Ryan White program(s) you are applying for:
_____Part B _____ Part C _____ ADAP _____ADAP Co-payment Assistance

If you live in Iowa, are you eligible for Iowa ADAP? _____Yes ____No _____Pending _____Don't Know
Date Eligible: _____ Reason Not Eligible: _____

Please tell us about you:

Legal Name: Last: _____ First: _____ MI: _____

Maiden/Other Names That You Use or Have Used: _____

Gender: Male: _____ Female: _____ Transgender: _____

Date of Birth: _____ Your Social Security Number: _____ - _____ - _____

City/State/Country you were born: City: _____ State:_____ Country: _____

Are you a U.S. citizen? Yes _____ No_____ **If foreign born, what is your Immigration status?**
_____ Refugee _____Visa (Type) _____ _____ Asylee
_____ Other (Please Specify_____)

What is your Primary Language? _____
Marital Status: ____Single ____Married ____Divorced ____Widowed ____Separated ____Partnered

Ethnicity/Race:
_____White _____African-American/Black
_____ African (Country) _____ _____Asian
_____American Indian, Alaskan Native _____ More Than One Race
_____Native Hawaiian or Other Pacific Islander

Hispanic or Latino(a) (Check one below):
_____Central American _____Cuban
_____Puerto Rican _____South American
_____Spanish, Portuguese _____Mexican/Mexican-American

_____Other (Please specify):_____

How Can We Contact You? *This application must be renewed at least every 6 months if you are using ADAP and once per year if you are using Part B (Title II) and/or Part C (Title III) for you to be considered for the particular program. We must rely on the contact information you have given us to reach you. It is important for you to tell us when you move or change your phone number.*

Home Phone: _____Cell Phone: _____If No Phone, Message Phone #:_____

Address Where You Reside: _____Apt:_____

City: _____ State: _____ Zip: _____

Mailing Address If Different From Above: _____Apt:_____

City: _____ State: _____ Zip: _____

Is it okay to send mail to your mailing address? Yes _____ No _____

HIV/AIDS Status: (Check all that apply)

HIV Positive: Yes_____ No____
Date of HIV+ Diagnosis: _____
City/State of HIV+ Diagnosis: _____ / _____

AIDS Diagnosis: Yes_____ No_____
Date of AIDS Diagnosis: _____
City/State of AIDS diagnosis: _____/ _____

What is your most recent CD4 Count? _____ Date: _____ Where completed?_____

What is your most recent Viral Load? _____ Date: _____ Where completed? _____

How were you Exposed to HIV?

_____ Men who have sex with men
_____ Injection drug use
_____ Men who have sex with men and Injection drug use
_____ Heterosexual contact
_____ Hemophilia/transfusion/other

Pediatric Exposure:

_____Sexual abuse/contact
_____Mother with or at risk for HIV
_____Hemophilia/transfusion/other

Care Providers/Emergency Contacts: Please complete as much as possible

Primary Care Doctor: _____ Phone #:_____

Address: _____

Doctor Providing HIV Care: _____ Phone #: _____

Address: _____

NAP Case Manager: _____

Emergency Contact: Name: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Relationship To You: _____ Is He/She Aware of Your HIV Status? Yes_____ No____

Emergency Contact: Name: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Relationship To You: _____ Is He/She Aware of Your HIV Status? Yes_____ No_____

Health Care Coverage:

Do You Have Health Care Coverage? _____Yes _____No (If you are employed, there is a possibility you have access to health insurance through your employer. If you do not know if you have health insurance available to you, please ask your supervisor.) **If you are working full time and do NOT have health insurance please tell us why:**

_____

If you do have health care coverage, please tell us if you have: (check all that apply)

_____ **Medicare** ____Part A ____Part B ____Part D

_____ **Medicaid** (Please indicate in what state _____)

_____ **CHAMPUS**

_____ **CHIP Policy** (Please indicate in what state _____)

_____ **VA Medical Benefits**

_____ **Health Insurance Policy through Employer**

_____ **Individual Health Insurance Policy**

_____ **Insurance Policy through Spouse's Employer**

_____ **COBRA Insurance Policy**

_____ **Primary Health Care/General Assistance**

_____ **Other (Please specify: _____)**

Name of Insurance Company: _____ _____ PPO_____ HMO ____POS

Insured's Name: _____ Insured's SS#:_____

Policy #:_____ Group #:_____

Address: _____ Customer Service Phone #: _____

Does your insurance cover all prescriptions? _____Yes _____No

Do you have a co-pay for prescriptions? _____Yes _____No

If yes, please indicate how much your co-pay is per prescription: $_____

Do you have access to coverage for eye care? _____Yes _____No

If yes, are you covered? _____Yes _____No

Do have access to coverage for mental health care? _____Yes _____No

If yes, are you covered? _____Yes _____No

Do you have access to dental coverage? _____Yes _____No

<u>Armed Forces</u>: (If you served in the Armed Forces you may be eligible for Veterans Administration benefits.)

Have you ever served in the Air Force, Army, Coast Guard, Marines, National Guard, Navy, or the Reserves?

____Yes ____No If Yes, Do you qualify for VA benefits _____Yes _____No ____Don't Know

If you have served in the Armed Forces you can learn more about possible Veterans Administration Medical Benefits by calling the VA Eligibility Benefits/Registration phone #: (800) 451-5796, Option 9, and then extension 3244).

<u>If Eligible for Medicaid and/or Medicare</u>:

Medicaid #_____

The State you are eligible in_____

Spend down Amount: $_____

Date applied: _____

Date eligible: _____

Pending: _____Yes _____No

If eligible, please provide the name of your Medicaid worker and his/her phone #:

Name: _____

Phone #: (_____) _____

If you applied and were denied, please tell us the reason you were given: _____

Medicare #_____

Part A Date Eligible: _____

Part B Date Eligible: _____

Have you enrolled in a Medicare Prescription Part D plan? ____Yes ____No
If Yes: Plan Name: _____

Are Medicare premiums deducted from your Social Security check? _____Yes _____No

Income/Benefits:

**** Proof of your income is required to determine eligibility for Ryan White Services. ****

To be considered for the Ryan White Program, you must provide proof of your income. This may be your Social Security Award Letter or your last two pay stubs. If you are paid in cash, please ask your employer for a letter stating how much you make per hour and the number of hours you work per week. If you do not have any income, please include a statement that includes the reason why and how you are being provided for. If you do not include your proof of income or an explanation as to how you are being provided for, your application will be considered incomplete, and we will not be able to process the application until this documentation is received.

Your Current Source of Income: (Please check all that apply)

_____**Full Time Employment** ____**Unemployment**

_____**Part Time Employment** ____**Self-Employment**

_____**Retirement/ Pension** ____**VA Benefits**

_____**Other** (Please Specify):_____

_____**Social Security Disability** (Date Found Disabled: _____ If pending when did you apply? _____)

_____**Short Term or Long Term Disability through job** (Date Began: _____ Date will end: _____)

Income/ Benefits (continued):

YOUR CURRENT HOUSING SITUATION: _____Rent _____Living with Family/Friends

_____Mortgage _____Homeless

How many people including yourself are you legally responsible for? _____

Please Complete- If Not applicable please indicate with N/A

GROSS INCOME: (per month)	AMOUNT	EXPENSES: (per month)	AMOUNT
Your Employment Income (before taxes/deductions/ garnishments)	$	Rent/Mortgage Payment	$
Self-employment	$	Utilities: Gas/Water Electric Phone Trash	$ $ $ $
Unemployment Compensation	$	Automobile Payment/ Transportation Expenses	$
Veterans Benefits	$	Automobile Insurance	$
Social Security Disability Income (SSDI)	$	Automobile Gasoline	$
Supplemental Security Income (SSI)	$	Health Insurance-Monthly Co-Pay Health Insurance–Yearly Deductible	$ $
Short Term Disability	$	Medical Bills	$
Long Term Disability	$	Pharmacy Expenses	$
Rental Property Income	$	Credit Cards	$
Worker's Compensation	$	Personal Loans	$
TANF (Temporary Assistance for Needy Families)	$	Student Loans	$
Food Stamps	$	Child Support	$
Relatives/Others	$	Food/Necessities	$
Other	$	Other Expenses	$
***TOTAL INCOME**	$	**TOTAL EXPENSES**	$

****Refer to Current HHS Poverty Guidelines for client eligibility information.***

I, _____, UNDERSTAND AND AGREE TO THE FOLLOWING:
(Please Print Clearly)

1. The standards for eligibility and participation in the Ryan White Part B Program, Ryan White Part C Program, and the Ryan White AIDS Drug Assistance Program (ADAP) are the same for everyone regardless of race, color, national origin, age, handicap or sex.

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 Programs, the University of Nebraska Medical Center Ryan White Part C, the Western Community Health Resources Ryan White Part C Early Intervention Services and the Iowa Ryan White Programs reserves 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 Care Coordinator, Case Manager, Provider, 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 Programs to discuss this application and all items related to my application, with my physician, pharmacy, service provider, dentist, social worker and caseworker as it relates to Ryan White 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 my physician, medical care provider, mental health care provider, pharmacy and treatment facility to release medical information and financial billing information pertaining to my care to the Nebraska Department of Health and Human Services, Ryan White Part B/ AIDS Drug Assistance Programs, The University of Nebraska Medical Center Ryan White Part C Program, the Western Community Health Resources Ryan White Part C Program and the Iowa Ryan White Programs. 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 Program Coordinator/Case Manager/Provider if there are any changes in my name, sex, address, living situation, physician/care provider, Medicaid/Medicare/private insurance status, marital status, residency/immigrant status, economic status, or any other life changes which may impact my eligibility for services. I understand that I must apply every six months for ADAP and annually for Ryan White Part B and Part C services so that the program can 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 disqualification of participation in Ryan White services.

***** Please note: Your Signature is required to determine your eligibility for Ryan Services*****

_____

SIGNATURE OF APPLICANT **DATE**

Case Manager Medicaid Certification:

Upon review/completion of this application, this is to certify that this client DOES/DOES NOT qualify for Medicaid assistance as of the date (update) of this application. **(Circle one)**

_____ _____

Case Manager/Provider **Date**