For Provider Use Only.
Check the box indicating which program applying for.

Name_____

☐ New applicant

Program: ☐ ADAP ☐ ADAP HIP ☐ ADAP co-payment assistance

☐ Part B ☐ Part C ☐ Part D ☐ Dental and Eye ☐ Medicaid co-payment exception

For UNMC Use Only

MRN:_____

Date application received:_____

Application: ☐ Complete ☐ Incomplete

If incomplete, missing the following: _____

Missing item due to UNMC by date: _____

Date processed: _____

Nebraska Ryan White Program Application Instructions

Complete the Nebraska Ryan White Program application to receive assistance with paying for your medical visits, medication payments and/or case management services.
Eligibility is determined based on your household income.

You must submit proof of your income, and if applicable, proof of income for your spouse and/or dependents.

Proof of income includes:

- Pay stub dated within the last 30 days
- Copy of page 1 of your most recent tax return
- Unemployment benefits statement
- Social Security Disability or Supplemental Security Income (SSI)
- Social Security Retirement, Survivor or Children Insurance Benefits
- Spousal (alimony) support
- Retirement or pension benefits (veterans, military, and commercial plans)
- Commercial short-term or long-term disability benefits
- Rental income
- Investments (interest, dividends, annuities, royalties, trusts)
- Worker's Compensation
- Other - such as Aid to Dependent Children (ADC)
- Cash

Application is incomplete if you do not submit proof of income.
Incomplete applications will not be processed.

Applicant Information

First Name	Last Name	MI

Social Security Number	Birth date

Current Gender: ☐ Male ☐ Female ☐ TransMale/Transman ☐ TransFemale/Transwoman
☐ Genderqueer ☐ Additional category: _____ ☐ Decline to state

Sex Assigned at Birth: ☐ Male ☐ Female

Residential Address (where you live)

Street		Apt#	
City	State	Zip Code	County

May we contact you at this address? ☐ Yes ☐ No
If you live in Iowa, are you eligible for Iowa ADAP? ☐ Yes ☐ No ☐ Pending
If yes, eligibility date: _____

Mailing Address Check here if same as residential address ☐

Street		Apt #	
City	State	Zip Code	County

May we contact you at this address? ☐ Yes ☐ No

Telephone and Email Address

Home number: _____ May we call you? ☐ Yes ☐ No

Cell number: _____ May we call you? ☐ Yes ☐ No

Email address: _____ May we email you? ☐ Yes ☐ No

Primary Language

☐ English	☐ Spanish	☐ Other: _____	☐ Need translation services

Ethnicity						
☐ Non-Hispanic						
☐ Hispanic:	☐ Mexican	☐ Puerto Rican	☐ Cuban	☐ Other Hispanic		
Race						
☐ White	☐ Black					
☐ Asian:						
☐ Asian Indian	☐ Chinese	☐ Filipino	☐ Japanese	☐ Korean	☐ Vietnamese	☐ Other Asian
☐ American Indian/Alaskan Native						
☐ Native Hawaiian/ Pacific Islander:						
☐ Native Hawaiian	☐ Guamanian	☐ Samoan	☐ Other Pacific Islander			
☐ Other: _____						
Sexual Orientation						
☐ Lesbian, gay or homosexual	☐ Straight or heterosexual	☐ Bisexual	☐ Something else	☐ Don't know	☐ Decline	

Citizen Status	
Are you a U.S. Citizen? ☐ Yes ☐ No If no, then are you a Legal Resident? ☐ Yes ☐ No Date of Legal Resident status: _____ Refugee ☐ Yes ☐ No	Country of Origin: _____

Marital Status				
☐ Single	☐ Married	☐ Divorced	☐ Widowed	☐ Partnered
Housing Status				
☐ Rent	☐ Mortgage	☐ Living with friend/family	☐ Homeless	☐ Other: _____

Emergency Contact			
Name	Aware of HIV status ☐ Yes ☐ No		
Relationship to applicant	Phone number		
Street address	City	State	Zip

Household Members

Not including yourself, what is the number of people you are legally responsible for? _____

☐ Check box if you are legally responsible for only yourself.

Household Income

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.** If applicant and/or spouse is paid in cash, then applicant must complete Income Verification form.

☐ Check box if you do not have an income and complete Income Verification form on page 8.

Household Member Name	Relationship	Income Source (wages, SSI/SSDI, cash, unemployment, etc)	Date Started Receiving Income	Monthly Gross Amount
1. **Applicant**	**Self**			$
2.				$
3.				$
4.				$
5.				$
				Total: $_____

Applicant's Employment Status			
How often are you paid? ☐ Daily ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Other: _____			
☐ Full time _____ hours per week $_____per hour	☐ Part time _____ hours per week $_____per hour	☐ Seasonal/temporary _____ hours per week $_____per hour	☐ Self employed

Federal Tax Information
Did you file or are planning to file your federal income taxes*? ☐ Yes ☐ No *If your insurance is through the Marketplace, you must file a tax return.

For UNMC Use Only: FPL%: _____

Health Insurance

Medicaid – ☐ Check box if not enrolled in Medicaid

Check the Medicaid program in which you are enrolled. *Provide copy of your Medicaid card.*

☐ Medicaid - disability ☐ Medicaid with spend down: Spend down amount $_____

☐ Medicaid - pregnant ☐ Medicaid for Families & Children

☐ Qualified Medicare Benefit (QMB or SLMB)

☐ Iowa Medicaid program ☐ Iowa Health and Wellness program

Describe Medicaid co-pay assistance exception: _____

Medicare – ☐ Check box if not enrolled in Medicare

Check all of the Medicare programs in which you are enrolled. *Provide copy of your Medicare card.*

☐ Covered under Part B (outpatient) ☐ Covered under Part D (prescription plan)

Plan name:_____

Private Health Insurance – ☐ Check box if not enrolled in private health insurance

Check the private health insurance program in which you are enrolled.

Provide copy of health insurance and prescription drug card.

☐ I am unsure if I am eligible for or covered by private health insurance

☐ Plan through my employer ☐ My employer offers health insurance, but I do not participate

☐ Through a retirement plan ☐ Under someone else's policy (spouse, partner, parent)

☐ Individual health insurance policy (self-insured) ☐ Under COBRA which expires on ____/____/_____

☐ Plan through Affordable Care Act

- ☐ Nebraska ADAP
- ☐ Iowa ADAP
- ☐ Self-purchase

Does your private insurance cover dental? ☐ Yes ☐ No ☐ Don't know

Does your private insurance cover vision? ☐ Yes ☐ No ☐ Don't know

Date insurance started: _____

Tricare – ☐ Check box if not enrolled in Tricare

Have you ever served in the Armed Forces? ☐ Yes ☐ No

If yes, are you eligible for Veteran's Benefits? ☐ Yes ☐ No ☐ Don't know

If you don't know, call 1.800.827.1000 or visit http://www.va.gov to determine eligibility.

Medical

Complete only if NOT a patient at Specialty Care Center at Nebraska Medicine.

HIV diagnostic date: _____/_____/_____ State residing when diagnosed with HIV: _____

Have you ever received an AIDS diagnosis? ☐ Yes ☐ No

If yes, AIDS diagnostic date: _____/_____/_____ State residing when diagnosed with AIDS: _____

Exposure category:

☐ Men who have sex with men ☐ Heterosexual contact ☐ Receipt of blood transfusion, blood components, or tissue
☐ Injection drug use ☐ Perinatal transmission

Most recent CD4 Count	Date	Most recent Viral Load	Date

HIV Doctor	Provider Clinic	Provider Telephone

When were you last seen by an HIV/AIDS specialist? _____/_____/_____

When is your next appointment with an HIV/AIDS specialist? _____/_____/_____

Are you currently taking HIV medications? ☐ Yes ☐ No If yes, date started taking: _____

If yes, list medications: _____

Have you ever been told by a medical provider you have Hepatitis C? ☐ Yes ☐ No

Have you ever been treated for Hepatitis C? ☐ Yes ☐ No Are you considering treatment? ☐ Yes ☐ No

Nebraska AIDS Project (NAP)

Do you have a NAP Case Manager? ☐ Yes ☐ No

If yes, case manager's name: _____

If no, would you like a NAP referral? ☐ Yes ☐ No

Ryan White Program Consumer Group

The Ryan White Program is always looking for ways to improve HIV-related services for consumers.

If you have suggestions or ideas, we want to hear from you!

Are you interested in being involved with the planning, delivery and assessment of HIV-related services?

☐ Yes ☐ No

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

Nebraska Ryan White Programs- Income Verification

If you and/or your spouse do not have an income or are paid in cash, then complete this page.

Check the box(es) in the No Income and/or Cash Income sections which best describes you and/or your spouse's income.

NO INCOME

☐ I do not have any income.

☐ My spouse does not have any income.

- I, _____, am applying for assistance through the Nebraska Ryan White Part B Program, the AIDS Drug Assistance Program (ADAP), Western Community Health Resources Panhandle Ryan White Part C Program and/or the University of Nebraska Medical Center Ryan White Parts C or D programs.
- I and/or my spouse have not received income since _____.
  Date
- I and/or my spouse do not expect to receive income until _____.
  Date
- At this time I am financially being provided for (food, shelter, utilities, clothing, etc.) by the following:
  _____
  _____.

CASH INCOME

☐ I am paid in cash.

☐ My spouse is paid in cash.

- I, _____, have stated that I and/or my spouse am paid in cash at this time and do not receive a paystub or payroll document. I receive this income on a _____ basis.
  hourly, daily, weekly, monthly
  I and/or my spouse currently work for _____.
  employer name
  My and/or my spouse's rate of pay is $_____ per _____.
  hourly, daily, weekly, monthly
- I understand that I and/or my spouse must provide a copy of any payroll or paycheck documentation should such documentation become available.
- This verification form is only valid when no other documentation of income is available. This form does not replace any payroll documentation, tax forms, paystubs, or award letters if available. This form must be updated at time of renewal and/or whenever there is a change in come or paystub/ payroll documentation becomes available.

I verify that all statements regarding my and/or my spouse's financial situation are true. I understand that should my and/or my spouse's income change, I am required to immediately notify the Ryan White Programs or my Nebraska AIDS Project case manager.

_____

Applicant Signature Date

Nebraska Ryan White Programs

Nebraska has the following Ryan White programs for consumers:

Part B: Supportive Services	**ADAP: AIDS Drug Assistance Program**	**Parts C & D: Medical Services**	**HOPWA: Housing Opportunities for Persons Living with AIDS:**
• Housing (rental) assistance • Utility assistance • Food assistance (limited non-food items) • Transportation assistance • Health insurance premium assistance • Case management (medical and non-medical) • Laboratory services • Translation services • Health education • Medical nutrition therapy • Limited legal planning (wills, DNRs, medical power of attorney) • Limited home health assistance • Minority outreach	• Medication payment assistance • Medication co-pay assistance • Health Insurance Program (HIP)	• HIV Counseling & Testing • Outpatient medical services • Women's health care • Medical case Management • Vision services (eye exam & glasses) • Dental services • Outpatient mental health services • Outpatient substance abuse services • Specialty referrals • Nutritional consultation	• Emergency rent or mortgage assistance • Tenant based rental assistance • First month's rent or security deposit • Housing locator website • Case management (standard and intensive) • Outreach • Self-sufficiency courses • Transportation • Resource identification • Substance abuse treatment (outpatient, if funds available) • Mental health treatment (outpatient if funds available)

Nebraska Ryan White 2016 Income Eligibility Table

To be eligible for services, annual income must not exceed 300% of the Federal Poverty Level (FPL).

Persons in Family/Household	**Annual Gross Income (300% FPL)**	**Monthly Gross Income (300% FPL)**
1	$35,640	$2,970
2	$48,060	$4,005
3	$60,480	$5,040
4	$72,900	$6,075
5	$85,320	$7,110
6	$97,740	$8,145
7	$110,190	$9,183

Keep this page as a reference for services and income guidelines.