CLEAR FORM

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
☐ Male ☐ Transgender – Male to Female
☐ Female ☐ Transgender – Female to Male

Gender Assigned At Birth
☐ Male ☐ Female

Language Preference
☐ English ☐ Spanish ☐ Other: _____

Social Security Number(SSN)*

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 # _____
Type: ☐Home ☐Cell ☐Work ☐Other
OK to leave messages? ☐Yes ☐No

Secondary Phone # _____
Type: ☐Home ☐Cell ☐Work ☐Other
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 Complete/Pre-App**

__-__-__/____ **Date Scanned**

__-__-__/____ **Date Entered in RWISE**

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: AHCCCS, DES, Medicare, utility bill, bank statement, other bills, check stubs
☐ Driver's License or AZ ID Card – *issued within the last year*
☐ Tribal enrollment – *most recent, not expired*
☐ 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.*
☐ Other award letter – *TANF, Unemployment, etc.*
☐ 1 month of check stubs or employment statement if no check stub is received. Must be dated within 60 days of the application
☐ Self-employment records – *use the Self Employment Worksheet and other documents as requested*
☐ Other income source not listed above –*requires Certification of income and/or Support*
☐ No Income – *requires Certification of Income and/or Support*

HOUSEHOLD INFORMATION TABLE

List every family member (legal spouse, biologic/adopted/step-children who live with you) and anyone you claim as a dependent on your taxes.

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
				☐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 Disability Insurance (SSDI)
☐Social Security Income (SS)
☐Supplemental Security Income (SSI)
☐Retired
☐Unemployed
☐Self-employed
☐Other (describe):_____

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 obtain food, 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:_____

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

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, Arizona School of Dentistry and Oral Health, Chicanos Por La Causa, Maricopa County Employee Benefits and Health, Ebony House, Maricopa Integrated Health System, Maricopa County Office of Health Education & Promotion, Phoenix Indian Medical Center, Southwest Center for HIV/AIDS, Sun Life, Terros, Ryan White HIV/AIDS Program Grantees and/or Contractors, all Ryan White Part B Grantees and/or Contractors, 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 to exchange my PHI or other information from my records to Ryan 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 OR
Arizona Department Health Services, 150 N. 18th Ave. Suite 130, Phoenix, AZ. 85007

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 or approval letter
- ☐ Medicare card
- ☐ 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 or Medical Provider Page (MPP))

☐ 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 (RWPA clients only)

☐ Medical Provider Page (MPP) completed and *signed* by your medical provider

ADDITIONAL SUPPORTING DOCUMENTS –Required under certain circumstances

☐ Benefit/Employment Verification Form

☐ 90 Day Medical Provider Override Form

☐ Affidavit of Understanding for individuals enrolled in a Federally Facilitated Marketplace plan

☐ Ryan White Self-Employment Worksheet