ARIZONA RYAN WHITE AND ADAP – HALF BIRTHDAY RENEWAL APPLICATION

Please complete the form below. If your income has changed since your last application, please provide one month's worth of income statements. If your insurance has changed since then, please provide copies of all current insurance cards.

APPLICANT INFORMATION

Last Name	First Name	Date of Birth
		__ __/ __ __/__ __ __ __

ADDRESS & PHONE

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

Primary Phone #	May we leave a message?	Other Phone #	May we leave a message?
( ) -	☐Yes ☐No	( ) -	☐Yes ☐No

HOUSEHOLD SIZE AND INCOME

Household Size	Monthly Gross Income	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):_____

HEALTH COVERAGE PAYER AND MEDICAL PROVIDER

☐AHCCCS
☐ALTCS
☐MEDICARE
☐A ☐B ☐D ☐Full LIS
☐Advantage Plan

☐Private – Employer:_____
☐Private – Individual:_____
☐FFM Plan:_____
☐Other:_____
☐No Insurance

☐Veterans Affairs
☐Indian Health Service
☐Federal Emergency Service
MEDICAL PROVIDER:

SIGNATURE

The information provided in this application is true and accurate to the best of my knowledge. Any unreported items may result in loss of eligibility. I will report any changes to my household income, household size, address, health insurance, and/or anything else that may affect my eligibility for services. If I do not, I may not be eligible or may have to re-pay the Ryan White Program.

Applicant Signature: _____ Date:_____

*By signing below, I affirm I have completed this renewal form with the client via phone on **(date)** ___/____/____ at **(time)** ____:____AM/PM*

Representative Signature: _____ Date:_____

Authorized Representative must be a Ryan White Case Manager, ADAP Representative or Central Eligibility Specialist

FOR OFFICE USE ONLY

Application Type: ☐Initial/New ☐½ Birthday Renewal ☐½ 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**