2023

Ending the HIV Epidemic (EHE) Application Manual

Department of Social Services

Office of HIV

I. GENERAL INFORMATION

Application Date: _____ ☐ Rapid stART ☐ Project Home

Process:

Eligibility Specialist will complete the following:

1. Application Date:
   - Date the complete application was received by the processing agency.

2. Rapid stART
   - Check here if client is referred to EHE **by a** Rapid stART provider.

3. Project Home
   - Check here if client **is being referred to** Project Home.

II. CONTACT INFORMATION

CONTACT INFORMATION

Legal Last Name:	Legal First Name:		Middle Name:	
Birth Date:		Preferred Name or AKA:		
Language Preference: ☐English ☐ Spanish ☐ Other: _____ In Need of a Translator: Yes ☐ No ☐		SSN or TIN*:		
Home Address:		City:	State:	Zip:
Mailing Address *(if different than home):*		City:	State:	Zip:
1. Phone – include area code:	Type:	May we contact you by phone? ☐ Yes ☐ No		
2. Phone – include area code:	Type:	May we leave a message? ☐ Yes ☐ No		
E-mail Address:	May we E-Mail you? ☐ Yes ☐ No	May we contact you by mail? ☐ Yes ☐ No		
		Should mail be confidential? ☐ Yes ☐ No		

**SSN/TIN information is not used for eligibility. It is used only to verify Medicaid or Health Insurance information.*

Process

1. Legal Last Name: Fill in with the client's actual LAST name.
2. Legal First Name: Fill in with the clients actual FIRST name.
3. Middle Name: Fill in with the Clients actual MIDDLE name.
4. Birth Date: Use the Drop-Down menu to determine the month, date and year client was born.
5. Preferred Name or AKA (optional) : Fill in with any known alias, or preferred name.
6. Language Preference: Check if language of choice is English, Spanish,

or Other. If other fill in the language of choice.

a. In Need of Translation or Interpretation Services: Check **Yes** if client is requesting translation services be made available when client is seeking services or write **No** if no translation or interpretation services are necessary.

7. SSN or TIN: Fill in with client's Social Security Number TIN Number. This information is used only to verify Medicaid or Health insurance information. If client does not or unable to provide you with an SSN or TIN put N/A. This information is **optional only**.
8. Home Address: Home address where client resides. (If client has no address, ensure that the client completes the attestation of homelessness).
9. City: Current city where client resides.
10. State: Put in Nevada. (Client must be a resident of Nevada to qualify)
11. Zip: Use current (Nevada) Zip Code.
12. Mail Address: Only if different from home address.
13. City: Only if different than (home) Home Address.
14. State: Only if different than (home) City Address.
15. Zip: Only if different than (home) Zip
16. Phone: Fill in with current primary phone number where client can be reached.
17. Type: Fill in what type of phone it is (cellular, land line etc.)
18. Phone: Fill in with current Secondary phone where they can be reached (Optional)
19. Type: Fill in what type of phone it is (cellular, landline, etc.)
20. E-Mail Address: Fill in with a client's email address (if available).
21. Ok to Receive Emails: Acknowledgment that the client agrees to receive email communication from the provider.
22. May We Contact You by Mail: Does the client give his consent to receive email from the provider
23. Should mail be confidential: Does the client prefer to have mail from the agency marked as private or confidential?
24. May we contact you by phone: Acknowledgment that the client agrees to communication from provider via telephone
25. May we leave a message: When a client is not readily available, can the provider leave a message for the client at the contact number.

***Note*:**

For Emergency Shelters (Trafficking Victims)

- Use client's P.O. Box for mailing address
- Write "confidential address" on the physical address section and in CAREWare Demographics tab
- Choose Verification of Residence Form or Letter from Landlord in the residencydocuments section and attach the letter from the landlord/agency representative

III. DEMOGRAPHICS

Demographic information allows us to better understand certain background

characteristics of our clients. This information helps the EHE Program communicate effectively with our service community, as well as understand the varied cultures of our clients, which may affect their health.

DEMOGRAPHICS

Gender Identity:
☐ Male ☐ Transgender Male-to-Female (MTF)
☐ Female ☐ Transgender Female-to-Male (FTM)
☐ Non-Binary ☐ Genderqueer/gender non-conforming
☐ Transgender Other: _____

Sex at Birth:
☐ Male
☐ Female
*As shown on Birth Certificate

Preferred Pronoun(s)

Ethnicity:
☐ Non-Hispanic/Latino
☐ Hispanic/Latino, (*if checked, choose an option below)*
☐ Mexican, Mexican American, Chicano/a
☐ Puerto Rican
☐ Cuban
☐ Other Hispanic/Latino: _____

Race:
☐ White
☐ Black
☐ American Indian/Alaskan Native
☐ Native Hawaiian/Pacific Islander (*if checked, choose an option below)*
☐ Native Hawaiian ☐ Guamanian/Chamorro
☐ Samoan ☐ Other Pacific Islander: _____
☐ Asian (*if checked, choose an option below)*
☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese
☐ Korean ☐ Vietnamese ☐ Other Asian: _____

Relationship Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Unmarried Couple ☐ Divorced ☐ Separated ☐ Widowed

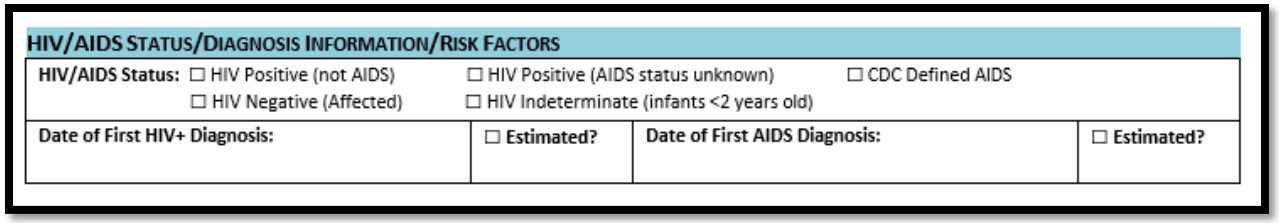
Are you a veteran? ☐ Yes ☐ No

Process

1. Current Gender Identity: How does the client currently identify themselves.
2. Sex at Birth: Check the appropriate box of the client's sex at birth.
3. Preferred Pronoun: What is the client's preferred pronouns when referring to themselves (optional)
4. Ethnicity: Check the box(es) that most accurately capture the choices the client identifies with.
5. Race: Check the race that most accurately capture the choice the client identifies with.
6. Relationship Status: Check the box identified/selected by the client
7. Are you a veteran: Is the client a veteran of the armed forces.

IV. HIV/AIDS STATUS AND DIAGNOSIS INFORMATION

An applicant is required to provide information regarding their HIV status. This includes where and when (even if estimated) they acquired HIV, how they acquired HIV and must provide documentation of a medical diagnosis of HIV disease with a laboratory test document confirming their HIV status for their initial determination of eligibility.

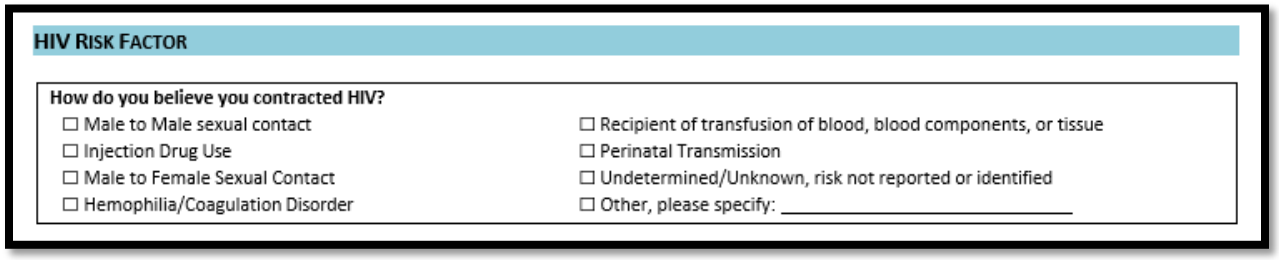


HIV/AIDS STATUS/DIAGNOSIS INFORMATION/RISK FACTORS

HIV/AIDS Status: ☐ HIV Positive (not AIDS) ☐ HIV Positive (AIDS status unknown) ☐ CDC Defined AIDS ☐ HIV Negative (Affected) ☐ HIV Indeterminate (infants <2 years old)			
Date of First HIV+ Diagnosis:	☐ **Estimated?**	**Date of First AIDS Diagnosis:**	☐ **Estimated?**

Process

1. HIV/AIDS Status: Check which choice best describes the client's current status:
   - HIV Positive (Not AIDS)
   - HIV Negative (Affected)
   - HIV Positive (AIDS status unknown)
   - HIV Indeterminate (infants <2 years old)
   - CDC Defined AIDS
2. Date of First HIV+ Diagnosis: Fill in with the date from documents, or if the client hasno documentation have the client give an estimated date.
3. Estimated Date: Check only if the Date of First HIV Diagnosis was estimated by client.
4. Date of First AIDS Diagnosis: Fill in with the date from documents, or if the client hasno documentation have the client give an estimated date.
5. Estimated Date: Check only if the Date of First HIV Diagnosis was estimated by client.



HIV RISK FACTOR

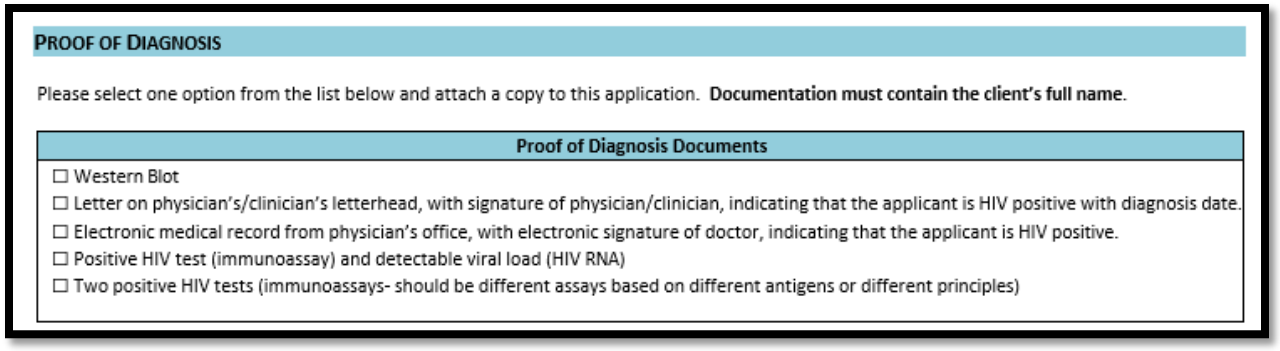
How do you believe you contracted HIV?

☐ Male to Male sexual contact	☐ Recipient of transfusion of blood, blood components, or tissue
☐ Injection Drug Use	☐ Perinatal Transmission
☐ Male to Female Sexual Contact	☐ Undetermined/Unknown, risk not reported or identified
☐ Hemophilia/Coagulation Disorder	☐ Other, please specify: _____

1. How do you believe you contracted HIV: Check the box(es) that best describes how the client contracted HIV.

Proof of Diagnosis

Documentation of HIV-positive status must be reviewed during onsite and/or remote visits and confirmed before initial enrollment by a case manager.



PROOF OF DIAGNOSIS

Please select one option from the list below and attach a copy to this application. **Documentation must contain the client's full name.**

Proof of Diagnosis Documents
☐ Western Blot
☐ Letter on physician's/clinician's letterhead, with signature of physician/clinician, indicating that the applicant is HIV positive with diagnosis date.
☐ Electronic medical record from physician's office, with electronic signature of doctor, indicating that the applicant is HIV positive.
☐ Positive HIV test (immunoassay) and detectable viral load (HIV RNA)
☐ Two positive HIV tests (immunoassays- should be different assays based on different antigens or different principles)

Process

The Eligibility Specialist will initiate the required documentation of confirmed HIV status through one of the following:

1. Western Blot Test:
2. Diagnosis letter on physician's Letterhead
3. Electronic medical record from physician's office
4. Positive HIV test (immunoassay)
5. Two positive HIV tests
6. Request for Proof of Diagnosis Form (CGD 15-39)

***Notes*:**

- Any proof of diagnosis document must include the applicant's full, legal name.

- A medical provider may submit a written statement confirming HIV diagnosis, on agency, clinic or public health department letterhead, a prescription pad or medical recordis acceptable. All medical providers' electronic medical record with signature is acceptable when warranted.

V. INCOME

An estimated annual gross income is for the purpose of determining if the client may qualify for Ryan White Services. Currently, a client's income has no bearing on their eligibly for EHE services.

INCOME

What is your estimated current annual gross income? $_____

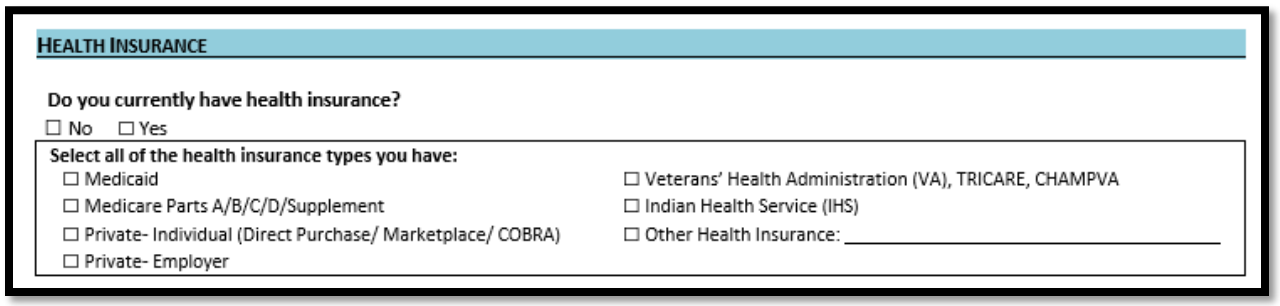
Process:

The Eligibility Specialist will inquire to the clients Annual Gross Income:

1. Enter Annual Gross Income

VI. HEALTH INSURANCE

The EHE Program is a Payer of Last Resort Program, which means that all possible options of other payer sources must first be utilized prior to any EHE funds being utilized/provided. This information will also assist in determining client's eligibility for insurance assistance if client is being referred for Ryan White eligibility.



HEALTH INSURANCE

Do you currently have health insurance?

☐ No ☐ Yes

Select all of the health insurance types you have:

☐ Medicaid
☐ Medicare Parts A/B/C/D/Supplement
☐ Private- Individual (Direct Purchase/ Marketplace/ COBRA)
☐ Private- Employer
☐ Veterans' Health Administration (VA), TRICARE, CHAMPVA
☐ Indian Health Service (IHS)
☐ Other Health Insurance: _____

Process

Do you currently have health insurance?

1. If No: check the **No** box.
2. If Yes:
   a. Select from the type if insurance types identified.
   b. Obtain a copy of the insurance card (front and back) and policy coverage and maintain a copy within the client's eligibility file.
   c. Determine the premium cost to the client, and if help is needed with their portion to maintain coverage.
   d. If assistance with premium payments is needed, refer the client (once determinedeligible) for Health Insurance Premium and Cost Sharing Assistance for Low-Income Individual services.

VI. Release of Information

A Release of Information is signed by the authorizing person (client or other authozied individual), allowing subrecipients to disclose or use the information through the consent of the client, a release of information is needed before subrecipients can process the data of the client for continued servcies.

RELEASE OF INFORMATION

I fully understand that by applying for this program, my information will be kept confidential. I also understand that supplied information or records associated with my case will not be released to anyone outside of the agency gathering the information without my informed written consent, a subpoena, court order, or legal statute.

In addition, by signing this form, I understand that the information contained may be used by staff to review my eligibility for this program and to verify all application information provided. By applying for this program, I understand that this does not mean that my application will be accepted, as eligibility requirements must be met, and funds are limited.

I fully release and hold Clark County, Office of HIV employees and agents harmless from any and all damages, losses, liabilities (joint or several), payments, obligations, penalties, clients, litigation, demands, defenses, judgments, suites, proceedings, costs, disbursements or expenses (including without limitation, fees, disbursements, and expenses of attorneys, and other professional advisors and of expert witnesses and costs of investigation and preparation) of any kind or nature relating to or arising out of my receipt of services.

I certify that the information provided in this application is true and accurate as of the date below and acknowledge that any intentional or negligent misrepresentation of the information may result in nullification of this application and termination of benefits and services.

Printed Name	Signature	Date

Process

1. Case manager will read or have the client read the above statement.
2. Client will print their name, sign and date where appropriate.