Nevada Ryan White All Parts Common Guidance Document 18-04A Universal Eligibility Application

Application Date: _____ ☐ Initial Application ☐ Annual Recertification

For Administrative Use Only:
New Ryan White Eligibility: Start Date: _____ End Date: _____
Case Manager/ Eligibility Specialist Name: _____
Subrecipient Agency: _____

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 (Optional)**	
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

SECONDARY CONTACT

Name:	**1. Phone – include area code:**	**Relation to the Client?**
Address:	**City:** / **State:** / **Zip:**	
Notes/Comments:	**Is the Secondary Contact Aware of client's status?** ☐ Yes ☐ No	

DEMOGRAPHICS

***Current Gender Identity:**
☐ Male ☐ Transgender Male-to-Female (MTF)
☐ Female ☐ Transgender Female-to-Male (FTM)
☐ Transgender Other: _____
☐ Refuse to Report (Prefer Not to Disclose)

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

Preferred Pronouns

***Race/Ethnicity:**
☐ White
☐ Black/African American
☐ 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: _____

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

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

Are you a veteran? ☐ Yes ☐ No

PROOF OF DIAGNOSIS (COMPLETED ONLY DURING INITIAL APPLICATION)

All clients must provide upon **initial enrollment only** one (1) medical/legal document from the list below indicating HIV infection. **Documentation must contain the client's full name**. Please select *one* option from the list below and **attach a copy** to this application

Proof of Diagnosis Documents
☐ Western Blot
☐ Letter on physician's letterhead, with signature of doctor, 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)
☐ Request for Proof of Diagnosis Form completed by applicant's physician (CGD 15-39)

HIV/AIDS STATUS/DIAGNOSIS INFORMATION/RISK FACTORS (COMPLETED ONLY DURING INITIAL APPLICATION)

***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?**

How do you believe you acquired HIV?

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

BASIC MEDICAL

How do you obtain primary HIV medical care?

☐ Publicly funded clinic or health district
☐ Private Practice
☐ Emergency Room
☐ Hospital Outpatient Center
☐ No primary source of care
☐ Other: _____

Primary Care Physician Name:	**HIV Specialist Name:**

RESIDENCY

***What is your current housing status?**

☐ I live in stable housing (includes HOPWA): ☐ Rent ☐ Own ☐ Long-Term Care Facility
☐ I live in temporary housing: ☐ Friends/Family (including couch-surfing) ☐ Hotel/Motel ☐ Transitional Housing or Treatment Center
☐ I live in unstable housing: ☐ Homeless/Emergency Shelter ☐ Jail/Prison/Detention Facility

All clients must provide one (1) residency document from the list below indicating Nevada residency.

- Please select *one* option from the list below and **attach a copy** to this application
- ***If your address changes at any time, please contact an Eligibility Specialist or Case Manager to update your address***

Residency Documentation	
☐ Current Lease/Rental Agreement	☐ Current Nevada Driver's License or State ID Card
☐ Rent/Mortgage Receipt (dated within the past 30 days)	☐ Consulate Identification Card
☐ Any Bill, Invoice, or Correspondence (dated within the past 30 days)	☐ Resident Alien Card
☐ Paycheck Stubs with Your Address	☐ Proof of Property Taxes Paid
☐ Letter from a Government Agency	☐ Voter Registration/Vehicle Registration
☐ Other Verifiable Government-Issued ID with Address	☐ Prison Release Papers
☐ Dependent Support Form (CGD 15-48) or a Letter: *See below*	☐ I am Homeless: *Complete the Attestation of Homelessness Below*
☐ Verification of Residence (CGD 15-50) or a Letter from Landlord	
If you cannot provide residency proof in your own name, please complete the Dependent Support Form (CGD 15-48) or submit a letter with your current address and a signature of person(s) providing support.	

Attestation of Homelessness
I attest that I am homeless or living in a shelter with no verifiable residence. I agree that if my residency status changes, I must immediately notify the Ryan White Part All Parts (ABCD) eligibility agency and provide documentation of residency. Client Signature: _____ Date: _____

HOUSEHOLD SIZE

List members of your household, such as a legal spouse and children who live with you, ***and*** anyone you will claim as a dependent on your taxes. *Please list yourself first.*

Client or Family Member Name	Relationship to Client	Does this person have Taxable Income?	Over age 18?	Claimed on Taxes?
	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
		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Total Household Size: _____

INCOME

Proof of household income is based on Modified Adjusted Gross Income (MAGI). Household income includes all income of anyone the client claims on their taxes or the income of someone who claims the client as a dependent on their taxes.

All clients and household members listed above must provide proof of income documentation from the list below, if applicable.

- ***If your income changes at any time, please contact an Eligibility Specialist or Case Manager to update your income.***

Income Source Documentation

Please select *all* income options that apply to your household from the list(s) below.

☐ Paycheck Stubs or Employment Statement for the last month *(most recent)*
☐ Annual Award Letter: Social Security, Supplemental Social Security (SSI), Social Security Disability Income (SSDI), Veterans Benefits, Annual Pension, Retirement, etc.
☐ Other Award Letter: Temporary Assistance for Needy Families (TANF), Unemployment, Child support/alimony etc.
☐ One (1) Month of Bank Statements *(only if pay stubs or annual statements cannot be provided)*
☐ Pre-Paid Debit Card Statements
☐ Profit and Loss Statement from Self-Employment (CGD 16-04)
☐ Other Source of Income: _____
☐ No Income: *Complete the Attestation of No Income Below*

How often are you or your spouse/household member paid?

Every Week:	☐ Self	☐ Spouse/Household
Every Two Weeks:	☐ Self	☐ Spouse/Household
Semi Monthly- *The 15th and 30th of the Month*:	☐ Self	☐ Spouse/Household
Monthly:	☐ Self	☐ Spouse/Household
Unstable Income:	☐ Self	☐ Spouse/Household

Monthly Self (before taxes) $ _____ **Monthly Spouse/Household (before taxes) $ _____**

Non-Taxable Income Sources

Do you, or anyone in your household, have any types of non-taxable income sources?

☐ No, I nor anyone in my household has non-taxable income sources.
☐ Yes, I or someone in my household has non-taxable income sources *(check all that apply - documentation must be provided)*

- ☐ Supplement Social Security Disability Income (SSDI)
- ☐ Workers Compensation
- ☐ Child Support (Received)
- ☐ Veteran's Disability Income
- ☐ Proceeds from Loans (Student/Bank Loans)
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

Monthly Self $ _____ **Monthly Spouse/Household $_____**

Taxable Income Sources

Do you, or anyone in your household, have any of the following types of taxable income sources?

☐ No, I nor anyone in my household has taxable income sources

☐ Yes, I or someone in my household has a taxable income source *(check all that apply – documentation must be provided)*

- ☐ Wages, Salary, & Tips (Gross- before taxes)
- ☐ Social Security Retirement Income
- ☐ Social Security Disability Income
- ☐ Business / Self Employment Income
- ☐ Taxable Interest and Dividends
- ☐ Capital Gains
- ☐ Rental Income (Net)
- ☐ Unemployment Compensation
- ☐ Taxable amount from Pensions & IRAs Distributions
- ☐ Other income not exempted (Jury Duty Pay, Gambling Winnings)

Monthly Self (before taxes) $ _____ **Monthly Spouse/Household (before taxes) $** _____

Deductions

Do you, or anyone in your household, have any of the following types of deductions?

☐ No, I nor anyone in my household has deductions.

☐ Yes, I or someone in my household has deductions *(check all that apply – documentation must be provided)*

- ☐ Health Savings Account Deductions
- ☐ Self-Employment Health Insurance Costs
- ☐ Health Costs (Insurance Premiums- Paid by Self)
- ☐ Workplace Retirement Plan: 401K
- ☐ Workplace Retirement Plan: 403B
- ☐ Traditional IRA (not a Roth IRA)

Monthly Self (before taxes) $_____ **Monthly Spouse/Household (before taxes) $** _____

FOR ADMINISTRATIVE USE ONLY

Monthly MAGI Income Formula: Monthly Taxable Income Sources minus (-) Monthly Deductions

For taxable income, follow these instructions to calculate monthly MAGI income:

- *If the individual is Paid Every Week, Every Two Weeks, or has Unstable Income: 1) Add the individual's checks together for the 30-day period, 2) Divide that by the number of checks to calculate an average, 3) Multiply the average by, 4.3 if paid weekly, or 2.15 if paid every two weeks. Repeat for each applicable individual (spouse or household member)*
- *If the individual is Paid Semi-Monthly: Add the two amounts together. Repeat for each applicable individual (spouse or household member).*
- *If the individual is Paid Monthly: No calculation is needed.*

Monthly MAGI Income: Self **$** _____ Spouse/Household **$** _____ *Note: (Non-Taxable Income is not included in MAGI)*

Annual MAGI Income: $_____

Attestation of No Income

I attest that I have no verifiable income. I agree that if my financial status changes, I must immediately notify the Ryan White Part All Parts (ABCD) eligibility agency and provide documentation of income.

I am receiving financial assistance with food, water, and basic needs from: _____

Client Signature: _____ Date: _____

HEALTH INSURANCE

Do you need assistance enrolling in insurance, paying your health insurance premiums, and/or medications? ☐ Yes ☐ No

Select all of the health insurance types you have, then complete all of the sections below:

- ☐ 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: _____
- ☐ **No Health Insurance**

Medicaid

Are you enrolled in Medicaid?

☐ Yes, I am enrolled in Medicaid Plan Name: _____

☐ I applied, but I was denied. Reason: _____

☐ I applied, but I am awaiting a decision.

☐ No, I am not enrolled because:

- ☐ I have other health insurance.
- ☐ I am not eligible; my income and assets exceed Medicaid eligibility requirements.
- ☐ I need a referral to Medicaid.
- ☐ My income is below 138% of the Federal Poverty Level (FPL), but I am declining a referral to Medicaid

Medicare

Are you enrolled in Medicare?

☐ Yes, I am enrolled in Medicare *(check all that apply)*

- ☐ Part A
- ☐ Part B
- ☐ Part C/ Medicare Advantage Plan/ Health Plan Plan Name: _____
- ☐ Part D/ Drug Plan Plan Name: _____
- ☐ Medicare Supplement or Retirement Plan Plan Name: _____

☐ No, I am not enrolled in Medicare.

☐ If you are enrolled in Medicare, do you receive Extra Help/ Low-Income Subsidy for your prescription drug costs? ☐ Yes ☐ No

Marketplace/ Nevada Health Link

Are you enrolled in a Marketplace Plan/ Nevada Health Link?

☐ Yes, I am enrolled in a Marketplace Plan/ Nevada Health Link Plan Name: _____

☐ I applied, but I was denied. Reason: _____

☐ I applied, but I am awaiting a decision.

☐ No, I am not enrolled because:

- ☐ I have other health insurance.
- ☐ I am waiting for the open-enrollment period.
- ☐ I need a referral to an insurance specialist for enrollment into a Marketplace Plan
- ☐ My income is between 139% and 400% of the Federal Poverty Level (FPL), but I am declining a referral to the Marketplace

Private or Employer Health Insurance

Are you enrolled in a private or employer-based health insurance plan?

☐ Yes, I am enrolled *check all that apply Plan Name: _____

- ☐ Employer Plan
- ☐ COBRA
- ☐ Spouse/ Domestic Partner/ Parent
- ☐ Private- Individual Plan (not Marketplace)

☐ No, I am not enrolled because:

- ☐ I have other insurance.
- ☐ I am waiting for my employer's open-enrollment period.
- ☐ I am not employed.

☐ No, I am not enrolled, but I may be able to get insurance through: ☐ Employer ☐ Spouse/ Domestic Partner/ Parent ☐ COBRA

If you or your spouse are employed and you are requesting premium or prescription assistance, you will be contacted by ADAP staff to complete the Employer Benefit Verification Form.

RYAN WHITE AND OTHER SERVICE NEEDS

Are you consistently taking your medications as prescribed?	☐ Yes	☐ No
Do you need counseling or education about your medications?	☐ Yes	☐ No
Do you need counseling or education about Risk Reduction?	☐ Yes	☐ No
Do you have issues with stress and/or depression in your life?	☐ Yes	☐ No

Which Ryan White Services do you need?

☐ Assistance with Food and Meals	☐ Legal Services	☐ Psychosocial Support/ Support Groups
☐ Case Management	☐ Medical Copayment Financial Assistance	☐ Substance Use Therapy
☐ Dental Care	☐ Medical Nutrition Therapy (Dietician)	☐ Transportation Assistance
☐ Emergency Financial Assistance (Utilities, Rent)	☐ Medication Assistance	☐ Treatment Adherence
☐ Health Education/Risk Reduction	☐ Mental Health Therapy	☐ Vision Care
☐ Health Insurance Premium Assistance	☐ Prenatal Care	☐ Other: _____
☐ Housing Assistance	☐ Primary or Specialty Medical Care	☐ Other: _____

RIGHTS AND RESPONSIBILITIES

The following statements reflect your rights and responsibilities as an individual seeking medical and support services from Ryan White All Parts (ABCD) Programs in the State of Nevada.

Client Rights

1. **Respect, Courtesy, and Privacy:** *You have the right to be treated at all times with respect and courtesy within a setting which provides you with the highest degree of privacy possible.*
2. **Freedom from Discrimination:** *You have the right to freedom from discrimination because of race, color, religion, sex, sexual orientation, gender identity or expression, age, disability, veteran's status, or national origin.*
3. **Access to HIV/AIDS Service Information:** *You have the right to be informed by your health care and/or social service provider about the full range of available HIV/AIDS treatments and about related available social and support services. You have the right to be advised of the risks and to discuss the benefits of any proposed treatments/services. You have the right to give your informed consent to any treatments/services or services before they are provided.*
4. **Identity and Provider Credentials:** *You have the right to know the names, titles, specialties, and affiliations of all health and social service providers, and anyone else involved in your care. You have the right to know about the health or social service organization's policies and procedures.*
5. **Culturally Sensitive Sharing of Information:** *You have the right to have information shared with you in a respectful manner that is easy to understand and takes into account the differences in each person's background, culture, and preferences.*
6. **Consent and the Care Plan:** *You have the right to be involved in the development of an individualized plan of care prior to and during the course of treatment. You have the right to disagree, change your mind, or request a medical second opinion without affecting the ongoing availability of treatment/services.*
7. **Choice and Access to Service:** *You have the right to be informed of all available services upon intake. You have the right to choose and receive all treatments/services for which you qualify.*
8. **Declining Service:** *You have the right to decline treatments/services without pressure from your healthcare or social service provider. You have the right to refuse to participate in any research studies or experiments that the provider may recommend. You have the right to change your mind after refusing or consenting to treatment, clinical trials, counseling, or any other service without affecting ongoing care.*
9. **Naming an Advocate:** *You have the right to choose an advocate. You may have more than one advocate (such as a family member or another person) to give you support and represent your rights.*
10. **An Advanced Directive for Care:** *You have the right to have advance directives, such as a Living Will, Healthcare Proxy, or Durable Power of Attorney for health and social services.*
11. **Access to Financial Information:** *You have the right to ask questions about and see all of your health care bills. You have the right to get referrals and help with any payment problems.*
12. **Confidentiality and Access to Records:** *You have the right to have all of your records kept strictly confidential, and not released without your permission. You have the right to access all of your records, unless the information is expressly excluded as outlined in HIPPA (Health Insurance Portability and Accountability Act), and to have copies of these at a fair copying cost.*
13. **Transferred and Continuity of Care:** *You have the right to uninterrupted treatments/services. If possible, your requests to leave one provider and be seen by another should be honored and happen as soon as possible. You may NOT be transferred to another provider or facility without an explanation for the transfer. You must be informed of other options that are available.*
14. **A Client Grievance Procedure:** *You have the right to voice complaints, to suggest changes, and to be informed about how to file a grievance (a formal written complaint). You have the right to do this without harassment, interference or pressure. You have the right to request a copy of an agency's grievance policy and procedures. You have the right to contact the Ryan White Recipient Offices to appeal an agency's decision about your grievance or at any point should you feel that the agency is not responsive to your grievance.*

Initials: _____

Client Responsibilities

1. **Respect, Courtesy, and Confidentiality:** *Health and social service providers have the right to be treated with respect and courtesy at all times.*
2. **Giving Correct and Complete Information**: You *are responsible for giving your provider accurate and complete information; you must give this information to the best of your ability. You are responsible for giving accurate and complete information about third party payers (such as insurance companies, Medicaid, Medicare) to your providers and their facilities*
3. **Seeking Facts About Your Case:** *You are responsible for asking questions about the care you are receiving if you do not completely understand*
4. **Following Treatment Plans:** *You are responsible for following treatment plans that you and your providers have agreed upon. You have the responsibility to tell your provider right away if you decide to stop your treatment or go against your provider's advice.*
5. **Scheduled Appointments:** *You are responsible for keeping appointments that you and your provider have scheduled. If you have to cancel, you are responsible for notifying your provider.*
6. **Rules and Regulations of Service Provider Organizations: You** *are responsible for following the rules and regulations of your providers and their agencies/facilities.*
7. **Voicing Complaints and Grievances:** *You are responsible for voicing complaints and presenting grievances in a courteous, appropriate, and timely manner. You should do this by following the provider's grievance policy and procedure, and you may ask for help in doing this if you need it. You are responsible to appeal an agency's decision about your grievance to the Ryan White Recipient Offices or to contact the Recipient Offices if you feel the agency is not responsive to your grievance.*

Initials: _____

RELEASE OF CONFIDENTIAL INFORMATION

I hereby authorize any of the agencies listed below who participate in the community-based Ryan White All Parts (ABCD) Programs and HOPWA Programs in the State of Nevada to release and/or share information concerning my eligibility, medical record status, and information concerning my diagnosis and treatment. The following agencies/programs authorized are:

- ACCEPT
- Access to Healthcare Network
- Aid for AIDS of Nevada
- AIDS Healthcare Foundation
- Carson City Health and Human Services
- City of Las Vegas
- Clark County Social Service
- Community Counseling Center
- Community Outreach Medical Center
- Dignity Health
- Division of Public and Behavioral Health HIV Surveillance
- Golden Rainbow
- CAN Community Health
- Kirk Kerkorian School of Medicine / UNLV Health Maternal Child Wellness Program
- Your Health Insurance Company: _____
- Your Physician: _____
- Partner/Spouse/Other: _____
- Impact Exchange
- Magellan Rx – Pharmacy Benefits Manager
- Medicare
- Nevada Division of Welfare and Supportive Services
- Nevada Medicaid
- Northern Nevada HOPES
- Nye County Health & Human Services
- Southern Nevada Health District
- The Gay & Lesbian Center of Southern Nevada
- University Medical Center- Wellness Center
- University Nevada, Las Vegas School of Dental Medicine
- Woman's Development Center
- North Country Health Care
- Project HOME

Information may be released between the above listed agencies throughout the duration of my active enrollment in the Ryan White All Parts (ABCD) program. Only agencies at which I have sought or will seek services will have access to my shared information. I understand that my records are protected under federal HIPAA regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I may revoke this consent in writing any time, except to the extent that any action has been taken or services were rendered while it was or s still in force. I understand that by choosing to withdraw and I am no longer seeking services from Ryan White All Parts (ABCD) program. This consent expires automatically one (1) year from registration or previously signed consent.

ACKNOWLEDGEMENT

I fully understand that by applying for this program, I am divulging personal information that will be used to assist me with benefits associated with the Nevada Ryan White Parts A, B, C, D Programs. I understand this information will be kept confidential but will be used by staff to review my eligibility for this program. Also, by signing this form, I understand that the information contained within may be used 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 funds are limited, and eligibility requirements must be met.

I fully acknowledge:

1. **It is my responsibility to renew my eligibility every 6 months on or before my birth month and 6 months following (half-birth month).**
2. **It is my responsibility to report any changes to my household income, my address, my contact information, my health insurance, or any other information that may affect my eligibility or services.**
3. **If I fail to recertify, my eligibility and benefits will be suspended.**

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 a termination of benefits.

Client Printed Name	**Client Signature**	**Date**
Printed Name of Representative	**Signature of Representative**	**Date**