Las Vegas TGA Application for HIV/AIDS Services
Ryan White Parts A, C, and D
(Please Print)

Application Date: 01/05/2015 ☐ New Application ☐ Update/Re-certification ☐ Re-open (break in coverage)

Contact Information

Legal Name: **Last, First, Middle Initial**		**Goes by or AKA:**		
Birth Date:	**SSN or Identifier:**	**Primary Language:**		
Home Address:	**City:**	**St:**	**Zip:**	**Date:**
Mail Address:	**City:**	**St:**	**Zip:**	**Date:**
Previous Address:	**City:**	**St:**	**Zip:**	**Date:**

1. Phone – include area code:	**Type:**
2. Phone – include area code:	**Type:**
e-mail:	

May we contact you by mail? ☐ Yes ☐ No
Should mail be confidential? ☐ Yes ☐ No
May we contact you by phone? ☐ Yes ☐ No
Message OKAY? ☐ Yes ☐ No

Emergency Contact

Name:	**1. Phone – include area code:**	**2. Phone – include area code:**	
Address:	**City:**	**St:**	**Zip:**
Notes:			

Demographics

Current Gender: ☐ Male ☐ Female ☐ Unknown
☐ Transgender Male-to-Female (MTF) ☐ Transgender Female-to-Male (FTM)
☐ Transgender (trans*, gender queer, gender non-conforming)

Sex at birth: ☐ Male ☐ Female

Ethnicity:
☐ Non-Hispanic/Latino

☐ Hispanic/Latino
Hispanic/Latino Subgroup:
☐ Mexican, Mexican American, Chicano/a
☐ Puerto Rican
☐ Cuban
☐ Another Hispanic, Latino/a or Spanish origin

Race: ☐ White ☐ Black ☐ American Indian/Native Alaskan

☐ Native Hawaiian or Pacific Islander
Pacific Subgroup:
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander

☐ Asian
Asian Subgroup:
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian

Marital Status: ☐ Single ☐ Married ☐ Domestic Partnership ☐ Divorced ☐ Separated ☐ Widowed ☐ Unknown

Education: ☐ No High School ☐ Some High School ☐ High School Diploma/GED ☐ Trade/ Technical ☐ Some College ☐ College Degree ☐ Graduate Degree ☐ Unknown

Are you a veteran? ☐ Yes ☐ No

Special Needs:

Living Situation

Current Living Situation (check one): **Living Situation Since:** _____

☐ Homeless from the street
☐ Homeless from emergency shelter
☐ Transitional housing
☐ Psychiatric facility
☐ Substance abuse treatment facility
☐ Hospital or other medical facility
☐ Jail/ Prison
☐ Rented Room
☐ Domestic violence situation
☐ Living w/ relatives or friend
☐ Rental Housing
☐ Own home
☐ Board care or assisted living
☐ Refused to answer
☐ Other
☐ Unknown

If you rent or own, do you have a signed lease, title or tax receipt? _____

Family/Household and Financial Information

Family/Household Information

Please list information on spouse, children, and any dependents in the table below (must be completed to claim dependents).

Name	Relationship	Age

Total Number of People in Family/Household (including you): _____

Is anyone in your household HIV+ and in need of Ryan White services? If so, please discuss this with the eligibility specialist at this time so that they can be referred to Ryan White services appropriately.

Financial Information

1. Are you employed? ☐ Yes ☐ No
2. If you are married or in a registered domestic partnership, is your spouse/partner employed? ☐ Yes ☐ No
3. Do you receive unearned income? (social security, child support, etc.) ☐ Yes ☐ No
4. Do you receive any public assistance? (social security, child support, etc.) ☐ Yes ☐ No
5. If **NO**, what is your source of income? _____

NOTE: If client has no visible means of support, they must complete the verification of no income form and dependent support form.

Legal Name: Last, First Middle	Social Sec # or Identifier

Modified Adjusted Gross Income (MAGI) Calculation

Use the tables below to estimate client's MAGI for the most recent month
For income losses, enter negative $ amounts.
*Items with an asterisk do not count towards total income. Include these items in both tables so they cancel out.

MAGI Income Sources – Total Monthly $ Amount for All Household Members			
***Supplemental Income from Social Security (SSI)**		Pensions & Annuities (Veteran/Employer Based Pensions, Retirement)	
***Child support received, workers comp, monetary gifts**		Retirement Security (SSA) Income from Social	
Other income (Jury Duty Pay)		IRA Distributions - Taxable amount	
Disability Income from Social Security (SSDI)		Capital Gain/Loss	
Wages, Salaries, tips, etc.		Other Gains/Losses	
Unemployment Income		Business Income/Loss	
Alimony or other Spousal Support Received		Farm income or loss	
Gambling Winnings		Rental real estate partnerships, S Corporations, Trusts, etc.	
Taxable refunds of State/Local Income Taxes			
Total Column 1 =	0	**Total Column 2 =**	0
Total Column 1 + Total Column 2 = Gross Income =	0		

Non MAGI Income Sources – Total Monthly $ Amount for All Household Members (needed to calculate adjustments)			
***Supplemental Income from Social Security (SSI)**		Court Ordered Child Support	
		Government Tax Liens	
***Child support received, workers comp, monetary gifts**		Penalty on Early Withdrawal of Savings	
Business Expenses		Alimony /court ordered spousal support paid	
Educator Expenses		IRA deduction	
Health Savings Account		Student Loan Interest Deduction	
Moving Expenses		Tuition and Fees	
Self-Employed SEP, SIMPLE plans		Domestic Production Activities	
Self-Employed Health Insurance		Court Costs/Probation Fees	
Health Insurance Costs and Co-Pays		Deductible Part of Self Employment Tax	
Total Column 1 =	0	**Total Column 2 =**	0
Total Column 1 + Total Column 2 = Total Income Adjustments =	0		

Modified adjusted Gross Income (for most recent month)	=	**Gross Income**	-	**Total Income Adjustments**	=	
		0		0		0

** To calculate annual income, multiply the monthly income by 12; be sure to enter annual income in CAREWare.

Annual Income	=	**MAGI (for month)**	X		=	
		0		12		0

HIV/AIDS Status and Diagnosis Information (***complete only at initial enrollment***)

CDC Disease Stage

☐ HIV Negative ☐ HIV +, stage unknown ☐ HIV +, symptomatic, not AIDS ☐ HIV +, disabling

☐ CDC Defined AIDS ☐ AIDS, disabling ☐ Pediatric, indeterminate ☐ Unreported ☐ Unknown

Source: _____

Date of First HIV+ Diagnosis:	☐ **Estimated?**	**County:**	**State:**
Date of First AIDS Diagnosis:	☐ **Estimated?**	**County:**	**State:**

How were you infected with HIV/AIDS?

☐ Male to Male sexual contact

☐ Injection Drug Use

☐ Heterosexual 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:_____

Health Care Coverage

Do you have some type of health care coverage – public or private?

☐ **YES**. I have the following types of health care coverage (please check all that apply):

☐ Indian Health Service (IHS) benefits

☐ Medicaid

☐ Medicare Part A/B

☐ Medicare Part D

☐ Medicare, other

☐ Private insurance through work

☐ Private insurance I enrolled in as an individual

☐ Veteran's Administration (VA), Tricare, other military health care

☐ Other, please specify:

_____

Does the Ryan White Part B/ADAP program help pay for your health insurance? ☐ Yes ☐ No

Medical Insurance Details

Source	Type	Carrier	Policy #	Start / End Date	Monthly Prem. $	Other notes

☐ **NO**. I do not have health care coverage at this time.

You must make every effort to enroll in health care coverage. Your eligibility specialist/case manager will work with you to create an enrollment plan. If you do not enroll in a health plan, you may have to pay a fee that increases every year. Currently, you can continue to receive Ryan White Part A, C, and D services, however, failure to do so by 2016 may result in a loss of Ryan White benefits.

If you are undocumented, you will not qualify for health care coverage and do not need to apply.

If you are exempt from enrolling, you will need to provide a certificate of exemption.

Basic Medical

Medical Providers

Primary Med. Care	Name	Phone	Last Visit Date
HIV Med. Care	Name	Phone	Last Visit Date

CD4 & Viral Loads

CD4 Date	T-Cell Count	%	Viral Load Date	< = >	Value	Test Type	Log

Pharmacies

Pharmacy Name	Phone	Allergies

Anti-Retroviral Drugs

ART Drug	Prescribed by	Side Effects	Start Date	End Date	Dosage

Ryan White and Other Service Needs

Which Ryan White Services do you need?

☐ Medical care
☐ Medical case management
☐ Dental care
☐ Vision
☐ Housing assistance
☐ Medical nutrition therapy (dietician)
☐ Assistance with food and meals
☐ Mental health therapy
☐ Psychiatric care
☐ Substance use therapy
☐ Support group
☐ Health education/prevention
☐ Treatment adherence
☐ Transportation assistance
☐ Other_____

Other publicly funded medical/supportive service programs client is eligible for:

_____

Denials from other publicly funded programs:

_____

Legal Name: Last, First Middle	Social Sec # or Identifier

Have you ever applied for assistance under any other name?

☐ No ☐ Yes

If yes, what names have you used?_____

_____

Have you ever applied for Ryan White services in any other State?

☐ No ☐ Yes

If yes, what state?_____

Approximate date?_____

For Part A, B, C, D

Under penalty of perjury, I swear or affirm that all of the information supplied by me in this affidavit is complete, true and correct, and the State of Nevada/Clark County may rely on this information. I, therefore, release all records to the state/Clark County to perform a verification of all application information provided. If I deliberately misrepresent information on this application my benefits will be terminated immediately and I may be prosecuted under applicable State & Federal Statutes, including but not limited to criminal charges, fines and property liens. I understand that I may be held personally liable for the cost of all drugs and support services if I deliberately falsified any documents or statements on this application.

It is my responsibility to renew my eligibility within 180 days of this application. If I fail to renew within the given time I may be placed on a waiting list, if one exists or I may need to wait for 5-10 days before I can receive my monthly drug allotments from the Ryan White Part-B program.

Print your full Legal Name _____ **Signature** _____ **Date** _____

I do not read English but I was assisted by _____ in understanding this form.

Notes and/or Additional Information:

_____

_____

_____

_____

Name of Patient's Physician	Phone Number	Fax Number
Ryan White Worker/ Patient Advocate Name (print)	**Phone Number**	**Fax Number**

General Ryan White Application Instructions

1. Every client should read the agreement on Page 6 **before** they fill out their application. Eligibility for any application is associated with the current policies and procedures.

2. The client must understand that the information entered in CAREWare will be the information that they give to the other agencies that they may visit. Their name, gender, social security number, and birth date must always be the same when they visit an agency for the first time. **A client cannot change their name without a legal document (court order and other legal documents such as Nevada ID or Nevada Driver's License).**

3. Be sure that the confidentiality preference is **always** checked off for mailings, phones and messages.

4. If a client is married or in a registered domestic partnership, they **MUST** declare the fact.

5. If a client's spouse/registered domestic partner is employed they **MUST** declare the fact.

6. All income requested in the MAGI table on p. 3 **MUST** be declared.

7. If available, clients must provide a copy of their annual IRS tax returns. If they DO NOT file a return, they must file a form that states that they are not required to do so.

8. Extraordinary expenses can be deducted from their gross income to lower their gross income. The payments must be in good standings to lower their income.

9. **Calculation of "MONTHLY" income.** If a client gets paid weekly, their "MONTHLY" income is calculated by multiplying the weekly amount by 4.3. If they get paid every two weeks "BI-WEEKLY" their MONTHLY income is calculated by multiplying the amount by 26 and dividing by 12. If they get paid SEMI-MONTHLY (2 times per month), multiply their income by 2 to get the MONTHLY amount.

10. A client must declare any medical coverage that they have (private, veterans benefits, Medicare, Medicaid, etc.). Failure to do so may result in a suspension of Ryan White benefits.

11. All clients who do not have health care coverage but are eligible for coverage are required to make an enrollment plan with their eligibility specialist/case manager and document their progress towards completing enrollment. Failure to enroll in health care coverage by 2016 may result in a loss of Ryan White benefits.

    Clients who are undocumented, will not qualify for health care coverage and do not need to apply. All other clients who are exempt from enrolling will need to provide a certificate of exemption.