RYAN WHITE PART B
PROGRAM APPLICATION

Demographics

Please Print Information Legibly Below

***First Name:**	***SSN:** ☐☐☐-☐☐-☐☐☐☐
Middle Name:	
***Last Name:**	***Date of Birth:** ☐☐/☐☐/☐☐☐☐
Name Suffix: ❍Sr. ❍Jr. ❍II ❍III ❍IV	
Nickname:	

***Sex at Birth:** ❍Male ❍Female

***Current Gender:** ❍Male ❍Female

***Marital Status:** ❍Single ❍Married ❍Divorced ❍Legally Separated ❍Partnered ❍Widowed

Were you born in the USA? ❍Yes ❍No **If No, Country of Origin:**

Primary Language:

***Ethnicity: (**Check all that apply)

❍ Non-Hispanic/Latino(a)

❍Hispanic/Latino(a) *(*If selected, specify*):
❍Mexican, Mexican American/Chicano(a) ❍Puerto Rican
❍Cuban ❍Other Hispanic/Latino(a) or Spanish origin

***Race:** (Check all that apply)

❍White

❍Black or African American

❍Asian *(*If selected, specify*):
❍Asian Indian ❍Chinese
❍Filipino ❍Japanese
❍Korean ❍Vietnamese
❍Other Asian

❍Native Hawaiian or Other Pacific Islander
*(*If selected, specify*):
❍Native Hawaiian ❍Guamanian or Chamorro
❍Samoan ❍Other Pacific Islander

❍ American Indian or Alaska Native

Referred by: ❍MAI ❍Self ❍Other: ❍No Referral

Name and phone # of person (if any) who helped you complete this form:

(☐☐☐)-☐☐☐-☐☐☐☐

Client Initials ☐☐

All fields marked with an asterisk (*) are mandatory/required fields.

Contact Information

Please Print Information Legibly Below

Residential Address:

Address 1:	**State:**
Address 2:	**Zip:** ☐☐☐☐☐
City:	**County:**

Mailing Address:

***Is Mailing Address the same as Residential Address?** ❍**Yes** ❍**No** *(Please enter Mailing Address below if different)*:

Address 1:	**State:**
Address 2:	**Zip:** ☐☐☐☐☐
City:	**County:**

The address you listed above is where we will send mail to you.

***Is it OK to mail to this address?** ❍**Yes** ❍**No**

Medication Shipping Address

***Where is your medication to be sent?**

❍**Residential Address** ❍**Mailing Address** ❍**Not Applicable - not on HIV Medication** ❍**Medication Address**

(Cannot be Case Management Agency Address.):

Address 1:	**State:**
Address 2:	**Zip:** ☐☐☐☐☐
City:	**County:**

Telephones:

Cell:	(☐☐☐)-☐☐☐-☐☐☐☐	**Is it OK to leave message?**	❍Yes ❍No
Home:	(☐☐☐)-☐☐☐-☐☐☐☐	**Is it OK to leave message?**	❍Yes ❍No
Work:	(☐☐☐)-☐☐☐-☐☐☐☐	**Is it OK to leave message?**	❍Yes ❍No
Other:	(☐☐☐)-☐☐☐-☐☐☐☐	**Is it OK to leave message?**	❍Yes ❍No

Email Address:		**Alerts/Information to this email address?**	❍Yes ❍No

Client Initials ☐☐

All fields marked with an asterisk (*) are mandatory/required fields.

Contact Information (continued)

Please Print Information Legibly Below

***Ohio Residency Verification Documents Attached** *(Check all that apply)*:

- ❍ Driver's License
- ❍ State of Ohio ID
- ❍ Lease/Letter from Landlord
- ❍ Utility Bill
- ❍ Benefit/Award Letter
- ❍ Addressed Envelope
- ❍ Homeless
- ❍ Other *(If Other, specify)*:

Emergency Contact Information ***(This must be someone we can contact who knows your HIV status)*:**

Client Has Emergency Contact? ❍ Yes ❍ No (*If Yes, enter name below.*)

*First Name:

*Last Name:

Emergency Contact Relationship (*Select only one*):

- ❍ Brother
- ❍ Child
- ❍ Father
- ❍ Friend
- ❍ Mother
- ❍ Other Family Member
- ❍ Other Non-Family Member
- ❍ Partner
- ❍ Roommate
- ❍ Sister
- ❍ Spouse

*Emergency Contact Phone Number: ( ) - -

Case Manager

Applicants with income less than 100% of the current Federal Poverty Level are required to have a case manager.

Agency Name:

Agency Telephone Number: ( ) - -

Agency Fax: ( ) - -

Case Manager:

Case Manager Telephone Number: ( ) - -

Extension:

Case Manager Email:

Client Initials

All fields marked with an asterisk (*) are mandatory/required fields.

CLIENT

Financial Information

Please Print Information Legibly Below

Please make copies of this page and complete it for EACH company that employs the client.

Employment Status *(Check all that apply)*:	**I am paid:**
❍ Fulltime (40 or more hours per week)	❍ Weekly
❍ Self Employed	❍ Monthly
❍ Unemployed	❍ Yearly
❍ Part-time	❍ Every two weeks (bi-weekly)
❍ Disability	❍ Twice per month (bi-monthly)

Income Type	Gross Amount	Frequency	
Salary/Wages	$		
Private Disability Income:	$		
Social Security Disability Income (SSDI):	$	monthly	
Social Security Income (SSI):	$	monthly	
Veteran's Benefits per month:	$	monthly	
Other Income per month (Check all that apply):	$		❍ Alimony/Child Support
	$		❍ Pension
	$		❍ Unemployment
	$		❍ Worker's Compensation
	$		❍ Rental Income
	$		❍ Other - If Other, specify:
Annual Gross Income:	$		
Household Size*(including client)*:			

*__Income Verification Documents Attached:__ *(Select and attach all that apply)*:

❍ Benefits/Awards Letter ❍ Pay Stub

❍ Verification of Income Statement ❍ Tax Transcript (3 years of tax transcripts – Self Employed only)

❍ Other (*If Other, specify*):

Employer Name:

Client Initials

HOUSEHOLD
Income Information

Please Print Information Legibly Below

Proof of income must be provided for ALL members of the household who have income. Please make copies of this page and complete it for EACH employer for EACH household member.

*First Name:	*Relationship:
Middle Name:	*Date of Birth: ☐☐/☐☐/☐☐☐☐
*Last Name:	
Living at Same Address? ❍Yes ❍No	Covered by Insurance? ❍Yes ❍No
Household Member's Ryan White ID *(if applicable)*: ☐☐☐☐-☐☐☐☐☐☐☐	
*Is Household Member receiving any type of Income? ❍**Yes** ❍**No**	
*Is Household Member to be included in Income Calculation? ❍**Yes** ❍**No**	

Income Type	Gross Amount	Frequency	
Salary/Wages	$		
Private Disability Income:	$	monthly	
Social Security Disability Income (SSDI):	$	monthly	
Social Security Income (SSI):	$	monthly	
Veteran's Benefits per month:	$		
Other Income per month (Check all that apply):	$		❍ Alimony/Child Support
	$		❍ Pension
	$		❍ Unemployment
	$		❍ Worker's Compensation
	$		❍ Rental Income
	$		❍ Other (*If Other, specify*):
Annual Gross Income:	$		

*__Income Verification Documents Attached__ *(Select and attach all that apply)*__:__

❍Benefits/Awards Letter ❍Pay Stub

❍Verification of Income Statement ❍Tax Transcript (3 years of tax transcripts – Self Employed only)

❍Does not apply ❍Other (*If Other, specify*):

Employer Name:

Client Initials ☐☐

Other Household Members

Use this page to document household members and dependents who do NOT have income but who are included in the client's income calculation to determine program eligibility. *Please make copies of this page if necessary.*

*First Name:	*Relationship:
Middle Name:	*Date of Birth: __ __ / __ __ / __ __ __ __
*Last Name:	
Living at Same Address? ❍Yes ❍No	Covered by Insurance? ❍Yes ❍No
Household Member's Ryan White ID *(if applicable)*: __ __ __ __ - __ __ __ __ __ __	
*Is Household Member receiving any type of Income? ❍**Yes** ❍**No** *Is this Household Member to be included in the income calculation? ❍**Yes** ❍**No**	

*First Name:	*Relationship:
Middle Name:	*Date of Birth: __ __ / __ __ / __ __ __ __
*Last Name:	
Living at Same Address? ❍Yes ❍No	Covered by Insurance? ❍Yes ❍No
Household Member's Ryan White ID *(if applicable)*: __ __ __ __ - __ __ __ __ __ __	
*Is Household Member receiving any type of Income? ❍**Yes** ❍**No** *Is this Household Member to be included in the income calculation? ❍**Yes** ❍**No**	

*First Name:	*Relationship:
Middle Name:	*Date of Birth: __ __ / __ __ / __ __ __ __
*Last Name:	
Living at Same Address? ❍Yes ❍No	Covered by Insurance? ❍Yes ❍No
Household Member's Ryan White ID *(if applicable)*: __ __ __ __ - __ __ __ __ __ __	
*Is Household Member receiving any type of Income? ❍**Yes** ❍**No** *Is this Household Member to be included in the income calculation? ❍**Yes** ❍**No**	

*First Name:	*Relationship:
Middle Name:	*Date of Birth: __ __ / __ __ / __ __ __ __
*Last Name:	
Living at Same Address? ❍Yes ❍No	Covered by Insurance? ❍Yes ❍No
Household Member's Ryan White ID *(if applicable)*: __ __ __ __ - __ __ __ __ __ __	
*Is Household Member receiving any type of Income? ❍**Yes** ❍**No** *Is Household Member to be included in the income calculation? ❍**Yes** ❍**No**	

Client Initials __ __

Insurance

Please Print Information Legibly Below

*Client has Health Insurance, Medicare and/or Medicaid with Prescription Coverage? ❍Yes ❍No

*Client has applied for Medicaid? ❍Yes ❍No

If Yes, date of Medicaid Application: ☐☐/☐☐/☐☐☐☐

* Client has a Medicaid Determination Letter or Medicaid Card? ❍Yes ❍No

If Yes, date Medicaid Determination Letter received: ☐☐/☐☐/☐☐☐☐

Client has the following (*Select all that apply*):

- ❍ Health Insurance
- ❍ Medicare
- ❍ Prescription Coverage
- ❍ Medicaid
- ❍ Veteran's Benefit
- ❍ Other (*If Other, must specify*):

* ☐

HIPAA Release on file? ❍Yes ❍No

*If Yes, date signed: ☐☐/☐☐/☐☐☐☐

Client Initials ☐☐

Premiums

Please Print Information Legibly Below

Does Client want assistance with premium payments? ❍**Yes** ❍**No**

Health Insurance Coverage (*Select all that apply*):

- ❍ Private Health Insurance
  If yes, is this an ACA Marketplace Plan? ❍Yes ❍No
- ❍ Medicare Part A/B (*Ryan White Part B does not pay for these premiums*)
- ❍ Medicare Part C (Medicare Advantage Plan)
- ❍ Medicare Part D
- ❍ Medicaid Managed Care Plan

*COBRA ❍Yes ❍No

If Yes, provide dates below and attach a copy of your COBRA Election Form:

Start Date: ☐☐/☐☐/☐☐☐☐

End Date: ☐☐/☐☐/☐☐☐☐

Is the OHDAP client the Policy holder? ❍Yes ❍No

*If No, Enter Policy holder's name:

Is Policy Holder a Ryan White client? ❍Yes ❍No

If Yes, enter Policy Holder's date of birth:

☐☐/☐☐/☐☐☐☐

AND the last four digits of Policy Holder's Social Security Number:

☐☐☐☐

Holder's Policy/Member ID:

Health Plan/Policy Number:

Group Name:

Group Number:

Customer Service Telephone:

(☐☐☐)-☐☐☐-☐☐☐☐

Number of People covered by Policy? ☐☐

***Insurance Coverage** *(Select all that apply)*:

	Premium Amount
Health:	$
Dental:	$
Other:	$
If Other, specify (e.g., vision):	
Monthly Insurance Premium Cost:	$

Employer Providing Coverage:

Contact Person:

Telephone: (☐☐☐)-☐☐☐-☐☐☐☐

Client Initials ☐☐

Premiums (continued)

Please Print Information Legibly Below

Insurance Company Information:

*Insurance Company Name:	TIN:
	-

Payment Address:

Attn:	Telephone:
Payee:	( )- -
Address 1:	Fax:
Address 2:	( )- -
City:	Email:
State: Zip:	

Client Initials

***Insurance Verification Documents Attached:**

- ❍Legible copy of front of Insurance Card
- ❍Legible copy of back of Insurance Card
- ❍Explanation of Benefits (EOB) from Insurance Company
- ❍Explanation of Payment (EOP) from Insurance Company

Rx Copayments

Please Print Information Legibly Below

***Does Client want assistance with prescription (Rx) copayments?** ❍**Yes** ❍**No**

***Insurance Coverage (Select all that apply):**

❍	Private Health Insurance
❍	Medicare Part D
❍	Medicaid Managed Care

Medication Copayment Information:

*Business Name:	TIN: ▢▢-▢▢▢▢▢▢▢▢▢

Payment Address:

Attn:	Telephone: (▢▢▢)-▢▢▢-▢▢▢▢
Payee:	
Address 1:	Fax: (▢▢▢)-▢▢▢-▢▢▢▢
Address 2:	
City:	Email:
State: Zip: ▢▢▢▢▢	

Rx ID:		Rx Bin:	
Rx Group:		Rx PCN:	
Contact Person:		Telephone: (▢▢▢)-▢▢▢-▢▢▢▢	

Client Initials ▢▢

***Rx Copayment Verification Documents Attached:**

- ❍ Legible copy of front of Rx Card
- ❍ Legible copy of back of Rx Card

Medicaid

Please Print Information Legibly Below

Does Client want assistance with Medicaid Spenddown? ❍Yes ❍No

Medicaid Case Number:

Medicaid Billing Number:

Payment County:

Spenddown ❍Yes ❍No

If Yes, Spenddown Amount:

$

Client Initials

Medical Information
Client Self-Report

Please Print Information Legibly Below

*Do you have a healthcare provider for HIV / AIDS care? ❍Yes ❍No If Yes, enter provider's information below:

Provider First Name:	Address 1:		
Provider Last Name:	Address 2:		
	City:		
	State:	Zip:	
Telephone:	( )- -		

*Year of first positive HIV test:

Lowest CD4+ Count Ever (NADIR):

HIV Status: ❍HIV-Positive, Not AIDS ❍HIV-Positive, AIDS Status Unknown ❍CDC-defined AIDS

HIV Exposure Category:

❍MSM (Male having sex with another male)
❍IDU (Injection drug use)
❍Hemophilia/coagulation disorder
❍Heterosexual contact
❍Recipient of blood transfusion/blood components (other than clotting factor)
❍Perinatal transmission (from mother to baby)
❍Other (If yes, you must specify):
❍Unknown

*Is your doctor prescribing Antiretroviral Therapy (ART)? ❍Yes ❍No

*Have you been diagnosed with Hepatitis B? ❍Yes ❍No

*Have you been diagnosed with Hepatitis C? ❍Yes ❍No

*Are you pregnant? ❍Yes ❍No ❍Not Applicable

If Yes, Indicate Due Date: / /

Client Initials

VERIFICATION OF INCOME
FOR ALL APPLICANTS

I, _____ *(print applicant name)* swear or affirm that I currently do not receive income of any type that has not already been reported in my application for the Ohio Ryan White Part B programs including the OHIO HIV Drug Assistance Program (OHDAP). I understand that income includes all money received from work, even that which is not reported for tax purposes. Income also includes, but is not limited to, money received from retirement, investments, unemployment compensation, and disability benefits. I am aware that I must also report any and all income earned by a married spouse (if married) and parents (if a dependent).

I am aware that providing false, incomplete or inaccurate information regarding income or any other aspect of the application may result in my inability to receive further assistance from any and all Ryan White Part B funded programs.

Applicant Signature : _____

Date : ☐☐/☐☐/☐☐☐☐

NOTE: This form (Ryan White Part B Verification of Income) is also available as a stand-alone form (HEA 0169).

Document requiring signature on reverse side, this page left intentionally blank.

AUTHORIZATION FOR PROOF AND
RELEASE OF INFORMATION AND HIV/AIDS REPORTING

The number of HIV cases reported in Ohio determines funding for HIV/AIDS services. HIV/AIDS reporting has significant impact on the dollars available to assist individuals. Monies for the Ryan White Part B Programs (e.g., OHDAP, HIPP, medical case management, financial assistance, etc.) are granted to Ohio based upon the reported number of people living with HIV/AIDS in our state.

Ohio law mandates that HIV and AIDS cases be reported to the Ohio Department of Health.

I understand that submitting this application to the Ryan White Part B program at the Ohio Department of Health may generate a confidential HIV/AIDS case report form to comply with Ohio law.

I authorize the Ohio Department of Health to verify all the information stated in my application to receive Ryan White Part B services relative to my medical condition, program eligibility status, financial income and available resources, insurance benefits, and other sources of assistance available to me.

I understand that the Ohio Department of Health may communicate with any individual, entity, agency, or organization including my physician, my medical case manager, my county Department of Job and Family Services office, my emergency contact, or other provider listed on the application to determine my current, on-going, or future eligibility for program services or to assist me in receiving services through this or other program**s** for which I may be eligible.

I understand that I must inform the Ryan White Part B program if any of the information regarding my eligibility status (e.g., HIV status, Ohio residency status, financial/income status) changes in any way. I understand that providing false, incomplete, or inaccurate information may result in termination or denial of benefits or possible legal action.

By my signature below, I affirm that to the best of my knowledge and belief, the answers and information furnished are complete and correct. I agree to the release of my information to the necessary individuals, entities, organizations, and/or agencies as described above, including to verify the information I have provided. I understand Ohio mandates HIV and AIDS case reporting.

_____ _____

Signature of applicant (or guardian, if applicable) Date of Signature

Signature of applicant or person legally responsible for the applicant (if the applicant is a minor or a disabled dependent) is required. This authorization is good for a period of two (2) years from the date of signature unless revoked by the applicant in writing. Revoking this authorization may prevent the Ohio Department of Health from verifying the applicant's eligibility for program services.

Appeal Procedures

You may appeal to the Director of the Ohio Department of Health (or designee), if:

1) Your application for the Ryan White Part B Program assistance is denied OR
2) Your assistance via the Ryan White Part B program is terminated.

If you believe you have been discriminated against because of race, color, national origin, sex, sexual orientation, age, handicap, religion, or political belief, you have the right to file a complaint with the Ohio Department of Health, 246 N. High Street, Columbus, OH 43266-0118; or with the Secretary of the Department of Health and Human Services, Washington, DC 20201.

NOTE: This form (Ryan White Part B Authorization for Proof and Release of Information) is also available as a stand-alone form (HEA 0171).

Document requiring signature on reverse side, this page left intentionally blank.

INDIVIDUAL AUTHORIZATION FORM (HIPAA RELEASE)

INDIVIDUAL'S INFORMATION

Include information about the individual whose information will be released.

Name

DOB: / /

SSN - -

Address:

Member ID (on Insurance Card):

RELEASE/RECEIVE INFORMATION

In the box below, insert the person/organization allowed to release the information.

The following company is allowed to release the information requested (insert name of insurance company/employer if company is self-insured):

The information can be provided to: Health Insurance Premium Payment (HIPP) Program
Ohio Department of Health, 246 N. High Street, Columbus, OH 43215
1-800-777-4775

WHAT INFORMATION IS BEING RELEASED

The HIPP program of the Ohio Department of Health is the third-party payer of my insurance premium. As a result, I give my permission for release of the following information:

- Premium Information
- Payment History
- Policy Information
- Prescription Drug Benefit Information
- Correct address information to ensure prompt payment

PURPOSE OF RELEASE

The purpose of this release is to ensure prompt payment of my insurance premiums. As such, any communication from representatives of the HIPP program at the Ohio Department of Health will be in the interest of pursuing this effort.

EXPIRATION DATE

If not previously revoked in writing, this authorization will terminate three months from the date my coverage ends.

SIGNATURE

A copy of this authorization is available to me upon request and will serve as the original. I understand that if this information is to be received by individuals or organizations that are not health care providers, health care clearinghouses or health plans covered by federal privacy regulations, my information described above may be re-disclosed by the recipient unless protected by other state or federal law. This authorization is subject to revocation at any time upon written notice to the person/company specified above except to the extent that the person/company has already taken action on the disclosure prior to the revocation. I also understand that I may refuse to sign this authorization; however, my refusal to sign will prevent HIPP from providing services to me.

_____ Date: / /

Signature of insured adult, parent/guardian of minor insured

_____ Date: / /

Signature of legal representative of insured (if applicable)

If a legal representative of insured signs on behalf of the individual, a copy of the legal representative's authority must be attached to this form.

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION.

NOTE: This form (HIPAA Release) is also available as a stand-alone form (HEA 0170).

Document requiring signature on reverse side, this page left intentionally blank.

Financial Eligibility Guidelines
For OHDAP/HIPP/Spenddown and Core Medical Services

Gross income must be equal to or less than
300% of the Federal Poverty Level (FPL)
Effective April 1, 2015

Size of Family	Annual FPL (100%)	300% of Federal Poverty Level (FPL)			
		Annual Gross	Monthly Gross	Bi-Weekly Gross	Weekly Gross
1	11,770	35,310.00	2,942.50	1,358.08	679.04
2	15,930	47,790.00	3,982.50	1,838.08	919.04
3	20,090	60,270.00	5,022.50	2,318.08	1,159.04
4	24,250	72,750.00	6,062.50	2,798.08	1,399.04
5	28,410	85,230.00	7,102.50	3,278.08	1,639.04
6	32,570	97,710.00	8,142.50	3,758.08	1,879.04
7	36,730	110,190.00	9,182.50	4,238.08	2,119.04
8	40,890	122,670.00	10,222.50	4,718.08	2,359.04

Source: Federal Register. For families with more than 8 persons, add $4,160.00 for each additional person.

Method to Determine Client's Income for Program Eligibility

1. Identify length of pay period on income verification documents (e.g., pay stubs).

a. Monthly ..... 1 pay per calendar month
b. Bi-Monthly ..... 2 pays per calendar month
c. Bi-Weekly ..... 1 pay every 14 days/2 calendar weeks
d. Weekly ..... 1 pay every 7 days/1 calendar week

2. Calculate Gross Annual Income.

a. Monthly Amount ..... Multiply check amount by 12

b. Bi-Monthly Amount ..... Add two check amounts and divide by 2 to get an average, then multiply the average by 24.

c. Bi-Weekly Amount ..... Add two check amounts and divide by 2 to get an average, then multiply average by 26.

d. Weekly Amount ..... Add four check amounts and divide by 4 to get an average, then multiply average by 52.

3. Compare the calculated annual gross income with the program eligibility guidelines shown in chart above for appropriate family size.

Attachments Checklist

RESIDENCY VERIFICATION DOCUMENTS

Please include at least one of the following:

- Driver's License
- Utility Bill
- State of Ohio ID
- Benefit/Award Letter
- Lease/Letter from Landlord
- Addressed Postmarked Envelope
- Other

FINANCIAL VERIFICATION DOCUMENTS

All applications must include:

- Signed Verification of Income Statement

In addition, please include at least one of the following:

- Benefit/Award Letter
- Pay Stubs (4 consecutive weeks within 45 days of applying for services)
- Other

INSURANCE VERIFICATION DOCUMENTS

- Insurance Card (front and back)
- Prescription Card (front and back)
- Explanation of Benefits (EOB) Notice
- Explanation of Payments (EOP) Notice
- HIPAA Release
- Other

MEDICAL VERIFICATION DOCUMENTS

Please note that medical verification documents are required to establish that an individual is HIV+ and, thus, eligible for our services. At this time, it is not necessary to submit medical verification documents with each application unless there are some additional questions regarding client health.

- Lab Results, including any of the following:
  - CD4+ cell count
  - HIV RNA (viral load)
  - Positive HIV Serology Results
  - Genotype Results
  - Tropism Test
  - Abacavir HLA Antibody Test
  - Western Blot
  - Other (e.g., a hospital discharge letter specifying condition)

RELEASES OF INFORMATION

- Program Release
- Other Releases