Arizona Ryan White and ADAP Application

APPLICANT INFORMATION		
Legal Last Name	**Legal First Name**	**MI**

Birth date (month/day/year)	**AKA (including maiden & nicknames)**
Self-Identified Gender ☐ Male ☐ **Transgender – Male to Female** ☐ **Female** ☐ **Transgender – Female to Male**	**Gender Assigned At Birth** ☐ Male ☐ Female
Language Preference ☐ **English** ☐ Spanish ☐ Other: ___________________	**Social Security Number (SSN)***

Home Address ☐I Am Homeless	**Apt/Suite #**	**City**	**State**	**Zip Code**	**OK to Mail?** ☐ Yes ☐ No
Mailing Address (if different)	**Apt/Suite #**	**City**	**State**	**Zip Code**	**OK to Mail?** ☐ Yes ☐ No

Email Address	**OK to E-Mail?** ☐ Yes ☐No
Primary Phone # ____________________ **Type:** ☐**Home** ☐**Cell** ☐**Work** ☐**Other** **OK to leave messages?** ☐**Yes** ☐**No**	**Secondary Phone #** ____________________ **Type:** ☐Home ☐Cell ☐Work ☐Other **OK to leave messages?** ☐Yes ☐No

Alternative Contact Person & Relationship		**Phone Number**	**Aware of Status?** ☐ Yes ☐ No
Ryan White Case Manager Name	**Agency**	**Phone Number**	**Contact instead of client** ☐ Yes ☐ No
Doctor Name	**Clinic Name**	**Phone Number**	**Fax Number**

** SSN information is not used for eligibility determination. It is used to verify income, AHCCCS eligibility, and/or verify Medicare coverage.*

FOR OFFICE USE ONLY:

Application Type: ☐ Initial/New ☐ Birthday Renewal ☐ Birthday Re-Enrollment

Applicant is applying for: ☐ RWPA ☐ RWPB ☐ RWPC ☐ ADAP ☐ Dental

Date Received:___-___-___/___ ☐ Logged In/______ Assigned Reviewer:________________________

Date Reviewed:___-___-___/___ ☐ Complete ☐ Incomplete

☐ BVF distributed ___-___-___/___ ☐ MPP/Lab Request Sent to:__________________on ___-___-___/___

FOR INCOMPLETE APPLICATIONS

Missing Documents: DX $$ Res Labs Other: _____________________

Reminder Contact Date: ___-___-___/___ Type: E-Mail VM TC FF

Form to be sent: ___-___-___/___ Sent: ___-___-___/___ To Be Closed on: ___-___-___/___

Missing Documents received: ___-___-___/___

___–___–___/___ ___–___–___/___ ___–___–___/___ ___–___–___/___

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Date Complete	Date Sent to ADAP/CE	Date Entered in CW	Date Attached in CW

RESIDENCY

Please provide **ONE** of the following residency documents issued within the allowable timeframes.

- The documents must be dated and include the client's name and home address (no P.O. Boxes).
- **Attach copies to this application.**

RESIDENCY DOCUMENTS (check **ONE** and attach a copy of document)
☐Annual income award letter from a government agency or pension – *issued for the current year*
☐Mortgage, lease/rental agreement or non-permanent housing letter – *most recent, not expired*
☐Any Document or mail with the client's name and address – *issued within the last 60 days* Examples include: AHCCCS, DES, Medicare, utility bill, bank statement, other bills, check stubs
☐Driver's License or AZ ID Card – *issued within the last year*
☐Tribal enrollment – *most recent, not expired*
☐ US Immigration Identification Card – *most recent, not expired*
☐ Attestation of residency or homelessness from a social service provider, medical provider, or family/friend – signed within 30 days (use one of the attestations below or provide a signed and dated written statement with the client's name, date of birth, and address)

Residency Attestation

May be completed by Medical Provider, Case Manager, Ryan White Eligibility Specialist, Family or Friend

I affirm to the best of my knowledge :___________________________________

lives at :____

______________________________ ______________________________

Printed Name **Relationship to client**

______________________________ ______________________________

Signature **Date**

Attestation of Homelessness

Agency Use Only: May only be completed by a social service or medical provider

I affirm to the best of my knowledge :___________________________________

is homeless at this time.

______________________________ ______________________________

Staff Member Printed Name **Name of Provider Agency**

______________________________ ______________________________

Staff Member Signature **Date**

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INCOME AND HOUSEHOLD SIZE

Please provide income documents issued within the allowable timeframes. Attach copies to this application.

INCOME SOURCE DOCUMENTS (check all that apply and attach copies)
☐ Annual award letter *(Social Security, VA, annual pension, etc.)*
☐ Other award letter *(TANF, Unemployment, etc.)*
☐ 1 month of check stubs or employer statement if no check stub is received
☐ Self-employment records *(use Self-Employment Worksheet, and other documents as requested)*
☐ Other income source not listed above *(requires Certification of Income and/or Support)*
☐ No income *(requires Certification of Income and/or Support)*

HOUSEHOLD INFORMATION TABLE

List every family member (legal spouse, biological/adopted/step-children who live with you) and anyone you claim as a dependent on your taxes.

Applicant or Family Member Name	Relationship	Monthly Gross Income	Source	Over age 18?	Claimed on Taxes
Self	Applicant			☐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
Household Size:		**Total Monthly Income:**		**Total Annual Income**	

EMPLOYMENT STATUS FOR APPLICANT/ADULT IN THE FAMILY UNIT

☐ Working:____hours per week
☐ Seasonal/ Temporary
☐ Full or part-time college student
☐ Social Security Disability Insurance (SSDI)
☐ Social Security Income (SSI)
☐ Retired
☐ Unemployed
☐ Self-employed
☐Other (describe): ___________________
____

CERTIFICATE OF INCOME

I confirm that I am supporting myself in the following manner (check and complete all that apply):

☐ I am homeless or living in a shelter.

☐ I am receiving assistance for obtaining food, water, housing and clothing from: _______________________________
Please attach letter of support from this person or have this person complete the 'Certificate of Support' below.

☐ Other: ____

I attest that, to the best of my knowledge and belief that the information submitted is accurate and complete.

CERTIFICATE OF SUPPORT

I, ___________________________, am providing support to _____________________________for him/her to obtain food, water, housing, and clothing.

____ ____
Signature **Date**

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MEDICAL/DENTAL INSURANCE/OTHER PAYOR

If you have medical coverage, please attach a copy of your health insurance card and prescription drug card.
You will be required to provide proof of denial for health insurance coverage if it appears you may be eligible.

HEALTH INSURANCE SCREENING

ARIZONA MEDICAID - AHCCCS

What is your AHCCCS Status?

☐ Enrolled - Plan Name: _______________________
Effective Date: ____/______/_____
☐ Pending - Date applied: ____/______/_____
☐ Denied – Date:____/______/_____
☐ FES Eligible
☐ Not Applicable: _________________

FEDERALLY FACILITATED MARKETPLACE (FFM) INSURANCE

What is your FFM Status?

☐ Enrolled - Plan Name: _______________________
Effective Date: ____/______/_____
☐ Pending - Date applied: ____/______/_____
☐ Pending Open Enrollment - Year____
☐ No SEP
☐ Not Applicable ☐ Categorically Ineligible ☐ Other Coverage

MEDICARE

What is your FFM Status?

☐ Enrolled - Effective Date: ____/______/_____
☐ A ☐ B ☐ D Plan:____________________
☐ Medicare Advantage ☐ Medicare Supplemental
Plan Name: ______________________________

Will you be eligible for in the next 12 Months?
☐Yes ☐No Effective Date: ____/______/_____
Have you ever been enrolled in Medicare?
☐Yes ☐No Dates of Coverage: ________ to _______

☐ Not Applicable ☐ <65 ☐ Not Disabled ☐ Categorically Ineligible

If you are enrolled in Medicare, what is your Extra-Help/Low-income subsidy?

☐ Enrolled -_____% Subsidy ☐ Pending - Date applied: ____/______/_____ ☐ Denied – Date:____/______/_____

OTHER GOVERNMENTAL HEALTH INSURANCE PROGRAMS

Are you eligible for or do you receive health services from Veterans Affairs? ☐Yes ☐No

Are you eligible for or do you receive health services from Indian Health Service? ☐Yes ☐No

PRIVATE OR EMPLOYER HEALTH INSURANCE

☐Enrolled Insurance Provider Plan Name: ___________________________________
I get insurance from: ☐ My Employer ☐ Spouse/Domestic Partner or Parent ☐Private, Individual plan ☐COBRA
Are prescription drugs covered? ☐Yes ☐No

☐ am not enrolled but, can get it from: ☐ My Employer ☐ Spouse/Domestic Partner or Parent ☐Private, Individual plan ☐COBRA

☐ am not eligible to get insurance through my employer, Spouse/Domestic Partner, Parent, or COBRA

If you and/or your spouse are employed but you do not have employer offered insurance coverage, have the employer complete the Benefit Verification Form.

DENTAL INSURANCE SCREENING

Are you eligible for, or enrolled in a dental insurance program other than Ryan White? ☐Yes ☐No Plan Name: _______________

Have you been denied dental insurance by a program you otherwise are eligible for? ☐Yes ☐No

REFERRAL NEEDS

Question	Response
Have you seen your health practitioner in the past 6 months?	☐Yes ☐No
Have you had lab work done in the past 6 months?	☐Yes ☐No
Are you taking HIV medications?	☐Yes ☐No
Is your housing or living situation stable?	☐Yes ☐No
Is your ability to provide your daily living needs stable?	☐Yes ☐No
Do you have transportation resources to meet your needs?	☐Yes ☐No
Do you have issues with stress and/or depression in your life?	☐Yes ☐No
Do you have addictions or substance abuse issues in your life?	☐Yes ☐No
Do you want a referral for help with any of the above issues?	☐Yes ☐No

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MEDICAL PROVIDER PAGE

MEDICAL PROVIDER SIGNATURE – ALL APPLICANTS

I certify that to the best of my knowledge and belief all information I have provided below is accurate and complete.

____ _________________________________

Signature of Medical Provider Date

PROVIDER INFORMATION AND LAB DATA – ALL APPLICANTS

Applicant Name		**Applicant Birth Date**		
Medical Provider Name		**License Number**		
Medical Provider Address	**Apt/Suite #**	**City**	**State**	**Zip Code**
Medical Provider Phone: ( )		**Medical Provider Fax:** (_____) ______________________________		

TESTS

Test Name	**Result**	**Date of Test**
FUTURE LAB DRAW DATE		
CD4 CELL COUNT (medical provider can follow DHHS guidelines)		
VIRAL LOAD (within the last 6 months)-**Required**		

HEPATITIS C SCREENING

Does Applicant have Hepatitis C?	☐Yes ☐No
Would Applicant like additional information about Hepatitis treatments through ADAP?	☐Yes ☐No

MEDICATION(S) PRESCRIBED – ADAP ONLY

PLEASE list full prescription below with a copy of prescriptions OR attach a copy of the eRX

Drug	Strength	Quantity	Instructions	# Refills

I certify that this applicant has been diagnosed as having HIV infection.

I understand that I am required to notify the vendor pharmacy within 7 calendar days of the following:

- Prescribing a new medication
- Discontinuing a medication

I agree to notify the Arizona ADAP/Ryan White programs within 14 calendar days following my notification of:

- Death of the patient/client
- Change in the HIV Medical Provider

If the client is going to go without Antiretroviral (ARV) Therapy for longer than 90 days or is on a ARV clinical trial, you will need to complete the *90 Day Medical Provider Override Form* , for questions please contact ADAP at 602-364-3610 OR 800-334-1540.

Please return to: ADAP, Arizona Dept. of Health Services
150 N. 18th Avenue, Suite 130, Phoenix, AZ 85007-3233
Fax: (602) 364-3263
Phone: Toll-Free (800) 334-1540

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RYAN WHITE PART A ONLY

Please review each statement and sign below:

- I may qualify for Ryan White funded services even if I have other insurance.
- I will report any changes to my household income, my address, and other things that may affect my services. If I do not, I may not be eligible or may have to re-pay the Ryan White Program
- At least every six months, I will complete the required eligibility process. If I fail to provide documents, I will not remain in the program.
- 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.

RYAN WHITE PART A RELEASE OF INFORMATION

I, ______________________________ (Client Name), authorize Care Directions, Arizona School of Dentistry and Oral Health, Chicanos Por La Causa, Maricopa County Employee Benefits and Health, Ebony House, Maricopa Integrated Health System, Maricopa County Office of Health Education & Promotion, Phoenix Indian Medical Center, Southwest Center for HIV/AIDS and Sun Life, Ryan White HIV/AIDS Program Grantees and/or Contractors, to disclose my protected health information (PHI) and other information from my records to any Ryan White HIV/AIDS Program (Ryan White) Grantee or Contractor operating in Maricopa County and/or Pinal County, Arizona.

The purpose of the disclosure is to permit Ryan White HIV/AIDS Program Grantees and/or Contractors to exchange my PHI or other information from my records to Ryan White Contractors and Grantees for the purposes of:

- Continuity of care, treatment, payment, and health care operations, including eligibility, demographic, emergency treatment, payments to Contractors or other statistical reporting information;
- Mandated reporting, including client-level data reporting;
- Disclosures required by law;
- Legal process and proceedings;
- Oversight including quality assurance reviews and audits of Ryan White-funded services provided;
- Disclosure to a Medical Examiner;
- Disclosure of notifiable public health conditions; and
- Inclusion in shared data systems for demographic, eligibility, and other statistical reporting.
- If in the course of providing services to a client, a RWPA provider identifies information that could be harmful to the client or the public, the provider may report that information to the appropriate authorities.

If required for the purposes listed above, I authorize the disclosure of the following information for the period of time from the date of my signature to one (1) year from the date of my signature:

- HIV/AIDS and other communicable disease information, including HIV Counseling and Testing;
- Behavioral, Mental Health or Psychiatric treatment information; and/or
- Substance abuse treatment information.

Unless I revoke this authorization earlier, it will expire one (1) year from the date of my signature. I also understand that my revocation will not apply to information that has already been released in response to this Release. To revoke this authorization, I must submit a written request to:

Central Eligibility Office, Care Directions
1366 E. Thomas Road, Suite 203, Phoenix, AZ 85014

By signing this Release of Information, I release all Ryan White Grantees and Contractors, their employees, officers, directors, medical staff, and agents from any legal responsibility or liability for the disclosure of information to the extent indicated and authorized in this Release. I also understand that Ryan White Grantees and Contractors will maintain the confidentiality of my disclosed PHI or other information, and that they will use my PHI or other information only for the purposes listed above.
I understand the matters discussed on this Release of Information and that by signing below, I acknowledge that I have received a copy of the Ryan White Program Notice of Privacy Practices, Central Eligibility Provider List, Client Rights/Responsibilities, and Client Grievance Policy.

___________________________	___________________________	______________
Printed Name	Signature	Date
___________________________	___________________________	
Signature of Legal Representative	Relationship to Client	

Arizona Ryan White and ADAP Application

ADAP/RYAN WHITE PART B ONLY

ADAP/RWPB RELEASE OF INFORMATION

Arizona Department of Health Services – AIDS Drug Assistance Program (ADAP) Application
(Under Provision of A.A.C. R9-6-401, et seq)

I agree that I or my designated representative must provide AZ ADAP with proof of ineligibility for enrollment for Arizona Health Care Cost Containment System (AHCCCS) and/or for Medicare Part D low-income subsidy, if not provided with this application. I also agree that I or my designated representative must provide AZ ADAP with proof of enrollment in a Medicare drug plan, if I am eligible for Medicare. Last, I agree that I or my designated representative must provide AZ ADAP with proof of or exception from enrollment in the Federally Facilitated Marketplace, if applicable.

I grant permission to AZ ADAP to share the minimum necessary information contained in this application with AHCCCS, for the purpose of determining AHCCCS eligibility, with Medicare and the Social Security Administration for the purpose of determining eligibility for a low-income subsidy and enrollment in a Medicare drug plan, with my primary care provider or their designee to confirm clinical information and acquire test results related to the service I am requesting, with the vendor pharmacy to assist with drug distribution, with other Ryan White providers in Arizona with whom I am enrolled to maintain my enrollment in ADAP or ADAP-Assist, and with any other entity as necessary to establish eligibility for enrollment in AZ ADAP, to maintain continuity of care, treatment, payment and health care operations.

I or my designated representative agrees to notify the AZ ADAP of any changes that affect my eligibility within 30 calendar days. Such changes include: any change in MAGI-based income, household size, residential or mailing address, phone number, employment status, availability of insurance coverage, AHCCCS eligibility, or primary care provider.

I understand that my AZ ADAP eligibility will terminate if I do not refill my AZ ADAP-covered Anti-Retroviral (ARV) medications for greater than 90 days.

I certify that to the best of my knowledge and belief, I am eligible for AZ ADAP and all statements made herein regarding personal and other non-medical information are accurate and complete. I certify that I am not eligible for any health insurance plan that would provide the support for which I am applying, other than those which I have declared.

I understand that my failure to be accurate and complete may prevent or delay a determination of eligibility to receive assistance from AZ ADAP, or may result in termination of my enrollment.

I understand that copies of the rules and policies for support documents are available upon request through the AZ ADAP Office.

I understand that if there is any discrepancy in the documents provided to AZ ADAP, I must present government issued documentation to confirm my identity.

I understand that AZ ADAP may terminate my enrollment in AZ ADAP if I exhibit violent or threatening behavior to a representative of the AZ ADAP or the AZ ADAP pharmacy.

I understand that AZ ADAP ceases to provide drugs when available funding is exhausted or terminated. AZ ADAP is not an entitlement program and does not create a right to assistance absent available funding (R9-6-402).

I,________________________________(applicant's printed name) authorize staff members of the Ryan White Part B and/or ADAP of the Arizona Department of Health Services, to represent me for the following purposes:

1. During my ADAP enrollment, facilitating the payment of premiums for marketplace coverage by the ADAP, provided that ADAP determines that the marketplace coverage remains the most cost effective means to provide me with HIV medications for which I am seeking assistance from ADAP. Please note that the Advance Premium Tax Credit (APTC) must be applied to total premium cost prior to ADAP facilitating the payment of premiums for marketplace coverage.
2. I further authorize Ryan White Part B employees, in their capacity as staff members of ADAP of the Arizona Department of Health Services, to disclose my confidential information to the extent necessary to carry out the three purposes listed above.

I understand and agree that this authorization will remain in effect for a period of one year from the date of signature.

Applicant Name (PRINT)	Signature	Date

Please return to: ADAP, Arizona Dept. of Health Services
150 N. 18th Avenue, Suite 130, Phoenix, AZ 85007-3233
Fax: (602) 364-3263
Phone: Toll-Free (800) 334-1540

SUPPORT DOCUMENT GUIDE

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REQUIRED SUPPORT DOCUMENTS – ALL APPLICANTS
☐ Proof of Residency – see page 2 for accepted documents
☐ Proof of Income – see page 3 for accepted documents ☐ Letter of Support – *if applicable* *If you signed the Certificate of Income and/or Support, the person helping you must provide a letter of support.*
☐ Proof of Healthcare Coverage (as applicable) ☐ AHCCCS card or approval letter ☐ Medicare card ☐ Private health insurance card
☐ AHCCCS Denial – dated within the calendar year (REQUIRED only for clients with income ≤ 150% FPL) • Denial due to failure to submit documentation is not accepted. • Enrollment in Federal Emergency Services (FES) is considered an AHCCCS denial. *If living in Maricopa or Pinal county, applicable denials will be generated through the Central Eligibility Office.*
☐ Viral Load Lab Results (Copy of Viral Load Lab report or Medical Provider Page (MPP))
☐ Income Template
REQUIRED SUPPORTING DOCUMENTS – ADAP/RWPB
☐ Medicare Extra Help/LIS Award or Denial Letter dated within the last 2 calendar years
☐ If you are or were enrolled in the FFM and receive premium assistance from ADAP, attach a copy of your federal taxes from the prior year
☐ Medical Provider Page (MPP) completed and signed by your medical provider (ADAP 340B clients only)
REQUIRED SUPPORTING DOCUMENTS – New Applicants Only
☐ New Applicant Addendum
☐ Proof of Diagnosis (RWPA clients only)
☐ Medical Provider Page (MPP) completed and signed by your medical provider
ADDITIONAL SUPPORTING DOCUMENTS –Required under certain circumstances
☐ Benefit/Employment Verification Form
☐ 90 Day Medical Provider Override Form
☐ SAAF Authorization for Use and Sharing of Information
☐ Ryan White Self-Employment Worksheet

Arizona Ryan White and ADAP Application

New Applicant Addendum (New Applicants Only)		
Name:	**DOB (mm/dd/yy):**	**Date:**
Refugee? ☐ Yes ☐ No **Asylum Seeker?** ☐ Yes ☐ No	**What was your Country of Birth:**_______________________ **What was your Country of Origin:** _____________________	
Ethnicity ☐ Non-Hispanic ☐ Hispanic Subgroup if applicable: ___________________________	**Race (choose all that apply)** ☐ White ☐ Black or African American ☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ American Indian/Alaska Native Subgroup if applicable: ___________________________	

Diagnosis Information
Date of HIV-positive diagnosis: ____/____/____ Is this date estimated? ☐Yes ☐No
Have you ever been told you have AIDS? ☐Yes ☐No
Date of AIDS diagnosis: ____/____/____ Is this date estimated? ☐Yes ☐No

Risk/Exposure Category (answer ALL questions)		
Have you ever had sex with a male?	☐Yes	☐No
Have you ever had sex with a female?	☐Yes	☐No
Have you ever used injection (IV) drugs?	☐Yes	☐No
Have you ever been diagnosed with hemophilia/coagulation disorder?	☐Yes	☐No
Have you ever received a blood transfusion?	☐Yes	☐No
Have you ever received an organ transplant?	☐Yes	☐No
Did you get HIV from your mother?	☐Yes	☐No

Diagnosis Documentation

New applicants must provide proof of their HIV-positive diagnosis. Documentation must have the applicant's full, legal name. Please attach to this application **one** of the documents listed below.
Check the box of which document is provided.

Confirmed Diagnosis
☐ Supplemental testing to confirm HIV diagnosis
☐ Lab report that shows a detectable viral load by dBNA or PCR

OR

Preliminary Diagnosis
☐ Preliminary positive screening test ***An authenticated lab report to confirm HIV diagnosis must be provided by the end of the following month***
☐ Other temporary proof of diagnosis (RWPA Only) ***An authenticated lab report to confirm HIV diagnosis must be provided by the end of the following month***

Arizona Ryan White and ADAP Application

BENEFIT/EMPLOYMENT VERIFICATION FORM

Employee Information

Employee Name (Last Name, First Name, MI)	**Employee Date of Birth**
Presently Employed ☐Yes If Yes, Date First Employed ______/________/_______	☐No If No, Last date of Employment ______/________/_______
Job Title	
Employment Status (Check ALL that apply) ☐ Full-Time ☐ Part-Time ☐ *Seasonal ☐*Temporary	***Describe Temporary/Seasonal Circumstance**

Current Wages/Salary:

$__________________

(Check one)	Hourly	Weekly	Bi-Weekly	Semi-Monthly	Monthly	Annual
	☐	☐	☐	☐	☐	☐

Insurance Eligibility

Is employee eligible for company offered healthcare benefits? ☐Yes ☐No

Employee currently enrolled? ☐Yes ☐No If No, Benefit Termination Date: ______/________/_______

If able, when can employee add a qualifying member? Date: ______/________/_______

Future Eligibility? ☐Yes ☐No

If Yes, Earliest date employee can enroll? ______________________________

If client were to enroll during that time, when would coverage take effect? _________________________

Insurance Information

Employee's portion of EMPLOYEE ONLY premiums for MEDICAL ONLY

$__________________

(Check one)	Hourly	Weekly	Bi-Weekly	Semi-Monthly	Monthly	Annual
	☐	☐	☐	☐	☐	☐

Insurance Carrier Name & Phone Number	**Are pharmacy benefits available?** ☐Yes ☐No

Additional Remarks

____

Employer/HR Print (First and Last Name)	**Date Form Completed**
Employer/HR Signature	**Applicant is responsible to return document for processing.**
Company Name	
Company Address	
Contact Phone Number	**REF URN: ______________**

Confidentiality Notice: This communication may contain confidential and/or proprietary information and may not be disclosed to anyone other than the intended addressee. Any other disclosure is strictly prohibited by law. If you are not the intended addressee or you have received this communication in error, please notify the sender immediately for instructions regarding the return or destruction of this communication including all content and any attachments. Thank you.

Arizona Ryan White and ADAP Application

BENEFIT/EMPLOYMENT VERIFICATION FORM

Employee Information

Employee Name (Last Name, First Name, MI)	**Employee Date of Birth**
Presently Employed ☐Yes If Yes, Date First Employed ______/________/_______	☐No If No, Last date of Employment ______/________/_______
Job Title	
Employment Status (Check ALL that apply) ☐ Full-Time ☐ Part-Time ☐ *Seasonal ☐*Temporary	***Describe Temporary/Seasonal Circumstance**

Current Wages/Salary:

	(Check one)	Hourly	Weekly	Bi-Weekly	Semi-Monthly	Monthly	Annual
$__________________		☐	☐	☐	☐	☐	☐

Insurance Eligibility

Is employee eligible for company offered healthcare benefits? ☐Yes ☐No

Employee currently enrolled? ☐Yes ☐No If No, Benefit Termination Date: ______/________/_______

If able, when can employee add a qualifying member? Date: ______/________/_______

Future Eligibility? ☐Yes ☐No

If Yes, Earliest date employee can enroll? ______________________________

If client were to enroll during that time, when would coverage take effect? _________________________

Insurance Information

Employee's portion of EMPLOYEE ONLY premiums for MEDICAL ONLY

	(Check one)	Hourly	Weekly	Bi-Weekly	Semi-Monthly	Monthly	Annual
$__________________		☐	☐	☐	☐	☐	☐

Insurance Carrier Name & Phone Number	**Are pharmacy benefits available?** ☐Yes ☐No

Additional Remarks

____

Employer/HR Print (First and Last Name)	**Date Form Completed**
Employer/HR Signature	
Company Name	
Company Address	
Contact Phone Number	

Please fax this completed Document back to (602) 364-3263

Attn: Eligibility Department

REF URN: ______________

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90 DAY MEDICAL PROVIDER OVERRIDE FORM

APPLICANT INFORMATION			
Applicant Name	Applicant Birth Date		
Applicant ADAP Assist ID Number (if applicable)			
PROVIDER INFORMATION			
Medical Provider Name	License Number		
Medical Provider Address Apt/Suite #	City	State	Zip Code
Medical Provider Phone: (______) ____________________	Medical Provider Fax: (______) ____________________		

Arizona ADAP/ADAP Assist Policy – Patients that have not received a refill of an Antiretroviral (ARV) medication (for the treatment of HIV infection) during a period of greater than 90 days are reviewed and subsequently disenrolled from ADAP/ADAP Assist unless the patient's HIV medical provider requests the patient be maintained on the AZ ADAP and/or ADAP Assist program for the specified reason(s) indicated. When/if a reduction in funding occurs affecting the ADAP program, clients who do not show current utilization of any Antiretroviral (ARV) medication(s) will be subject to immediate disenrollment.

Patients disenrolled from ADAP and/or ADAP Assist due to non-use of ARV medications may reapply to the program when they start ARV medications.

Please check the applicable boxes below, sign and date this form, and return it to ADAP or your patient may be disenrolled from the AZ ADAP and/or ADAP Assist program.

☐ My patient may be disenrolled from the AZ ADAP and/or ADAP Assist program and I understand that he or she may reapply at a later time when/if the client's starts ARV medications.

I request that my patient be maintained on AZ ADAP and/or ADAP Assist for the following reason(s):

Check all that apply

☐ This patient is treatment naïve and does not wish to start ARV medications at this time.

☐ This patient has a significant co-morbidity that requires treatment prior to the start of ARV medications.

☐ This patient has extra ARV medication that they are currently using.

☐ Other (please specify): ____

____

____________________________ ____________________

Medical Provider Signature Date

Please return to: ADAP, Arizona Dept. of Health Services
150 N. 18th Avenue, Suite 130, Phoenix, AZ 85007-3233
Fax: (602) 364-3263
Phone: Toll-Free (800) 334-1540
Ramsell Corporation – Phone: 888-311-7632 Fax: 510-587-2729

Arizona Ryan White and ADAP Application

SAAF STATEWIDE DENTAL/ADAP ASSIST AUTHORIZATION FOR USE AND SHARING OF INFORMATION		
APPLICANT INFORMATION		
Client Name (last name, First name)	**Date of Birth**	**Client ID:**

As a Southern Arizona AIDS Foundation Client, I understand that State and Federal regulations govern the confidentiality and protection of my individually identifiable health information (CFR 42 Part 2, CRS 25.1, HIPPA). Except in situations legally required or permitted, information about me cannot be given to persons or agencies outside the Southern Arizona AIDS Foundation without my written permission. I understand that additional protections exist for substance abuse information and for HIV/AIDS information.

I certify that this consent has been given freely and voluntarily. I hereby authorize the Southern Arizona AIDS Foundation to send, receive, exchange, use or share the following information about me to:

____

____

(Name of individual and/or Name of Agency or Program Address)

Information to be used or shared includes: *(The client or client representative must initial the information to be shared)*

______ Assessment, Diagnosis ______ Medication Assessments, Records ______ Evaluations or Testing Results

______ Social History, Background ______ Update or Discharge Summaries ______ Legal Information

______ Education Information ______ Substance Abuse Information ______ HIV/AIDS Information

______ Mental Health information ______ Other (specify) ____________________________________

The information is to be released will be used for the following purposes (check all that apply)

☐ At the request of the client ☐ Continuity of Care ☐ Eligibility determination

☐ Obtaining services or benefits summaries ☐ Service information for billing ☐ Program involvement

☐ Professional consultation ☐ Other (specify) ____

Other information about this authorization *(The client or client representative must initial the following statements)*

______ 1. My ability to get services at SAAF does not depend on signing this authorization. Some disclosures may be made without my permission if legally permitted or required.

______ 2. This authorization will expire in one year from the signature date. I may revoke my authorization at any time by signing the Revocation Statement below. SAAF cannot take back any information disclosed before I revoked this authorization.

______ 3. SAAF cannot guarantee that recipients of information disclosed through this authorization will not re-release it to another party. The recipients may or may not be subject to federal laws protecting health information. If the health information concerns substance abuse or HIV/AIDS, the recipient is not permitted to re-release it to anyone.

____________________	_______________	____________________
Client Signature	Date	Witness Signature
Representative	Date	(if applicable, relationship to client)

REVOCATION STATEMENT: I revoke my authorization for this use and sharing of information, effective immediately.

Client/Representative Signature: ______________________________________ Date: ____________________________

Southern Arizona AIDS Foundation 375 S. Euclid Ave., Tucson, AZ 85719 Phone: 520-628-7223 Fax: 520-628-6222

Arizona Ryan White and ADAP Application

RYAN WHITE SELF-EMPLOYMENT WORKSHEET

Please provide 3 months of all self-employment gross monthly income and expenses:

Applicant Name (First & Last Name)	**Date of Birth**
Type of Work:	

Month				**Annual**
Gross Income Total	$	$	$	$

Deductible Expense:				
Advertising				
Car/Truck Expenses				
Commissions/Fees				
Contract Labor				
Depletion				
Depreciation				
Employee Benefit Programs				
Insurance				
Interest (Mortgage)				
Interest (Other)				
Legal & Professional Services				
Office Expenses				
Pension & Profit-Share Plans				
Rent or Lease (vehicles, machinery, equipment)				
Rent or Lease (other business property)				
Repairs & Maintenance				
Supplies				
Taxes & Licenses				
Travel				
Deductible Meals & Entertainment				
Utilities				
Wages				
Other Expenses				
Expenses for business use of your home				
Costs of Goods Sold				
Expenses Total:	$	$	$	$

Adjusted Gross Income:	$	$	$	$

Client Signature ______________________ Date ______________________