Clear Form

Arizona Ryan White and ADAP Application

Completing the application will take about 30 minutes. It is recommended that you have, as many of the documents listed below, to assist you in completing the application and obtaining active enrollment status.

Recommended documents (if applicable):

- Residency Proof: *documents (proof of where you live), must be in Arizona*
- Income documentation: *source documents for you and everyone in your household*
- Current Labs: *document of your viral load dated within the past 6 months*
- AHCCCS determination letter (AHCCCS is Arizona's Medicaid)
- Medicare Extra Help/Low Income Subsidy (LIS) award or denial letter reflective of current income levels
- Summary of coverages, enrollment periods, plan costs, etc., for all health plans offered by an employer
- Medical, dental and prescription cards
- **For new applicants only**, included with your completed application, the New Applicant Addendum and proof of your diagnosis is required.

If deemed necessary by our Eligibility Specialists to assist in determining, your eligibility for the Arizona Ryan White Program services, they may request other documents, in addition to those listed above, be submitted for review.

If you need assistance or have any questions please contact the eligibility office at 602-364-3610.

ABOUT ME

Full Legal Name: _____

Legal First Name Middle Name Legal Last Name

☐ My Preferred and Legal First Name are the same. ☐ My Preferred and Legal Last Name are the same.

Preferred Name: _____ _____

Preferred First Name Preferred Last Name

Have you gone by any other names? _____

Please list any and all other names you have been known as, or have used. i.e. maiden names, prior legal name, etc.

Birth Date: (MM/DD/YYYY) _____

Do you have a valid Social Security Number? ☐ Yes ☐ No

Social Security Number (SSN): _____

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

Do you have an Arizona Driver's License or Arizona Identification Card? ☐ Yes ☐ No

AZ Driver's License # or AZ Identification # _____

Your preferred language:

☐ English ☐ Spanish ☐ French ☐ ASL ☐ Other: _____

What sex were you assigned at birth? ☐ Male ☐ Female

What gender do you identify as? ☐ Male ☐ Female ☐ Non-Binary ☐ Trans Male ☐ Trans Female

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RELEASE OF INFORMATION

Please review and initial each statement:

_____ 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 have to re-pay the Ryan White Program.

_____ The information provided in this application is accurate and complete to the best of my knowledge. Any unreported items may prevent, delay a decision about my eligibility, or result in loss of eligibility.

_____ I acknowledge that I have received a copy of the Ryan White Program Notice of Privacy Practices, Client Rights/Responsibilities, and Client Grievance Policy, as applicable.

_____ My enrollment may be terminated if I exhibit violent or threatening behavior to any Ryan White/ADAP Program representatives.

I, _____, authorize Care Directions, Arizona School of Dentistry and Oral Health, Chicanos Por La Causa, Ebony House, Valleywise Health, Maricopa County Department of Public Health, Phoenix Indian Medical Center, Southwest Center for HIV/AIDS, Sun Life, Terros Health, RipplePHX, Ryan White HIV/AIDS Program Grantees and/or Contractors, all Ryan White Part B Grantees and/or Contractors, all Rapid Start Network Community Partner Organizations, SAAF/Delta Dental and ADAP to disclose my protected health information (PHI) and other information from my records to any Ryan White HIV/AIDS Program (RWHAP) Grantee or Contractor operating in the State of Arizona.

The purpose of the disclosure is to permit RWHAP 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, health insurance premium and copay payment, emergency treatment, and/or 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 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 RWHAP Grantee or Contractor 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 until the end of the month, one (1) year from the date of my signature below:

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

Unless I revoke this authorization earlier, it will expire at the end of the month, one (1) year from the date of my acknowledgement below. 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 the following agencies:

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

OR

Arizona Department of Health Services, 150 N. 18th Ave, Suite 280, Phoenix, AZ 85007, careandservices@azdhs.gov

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.

By signing below, I acknowledge and understand the above statements.

Applicant Name	**Signature**	**Today's Date**

CONTACT INFO

PRIMARY PHONE NUMBER

☐ I do not have a phone number to provide at this time

What is your primary phone number? _____

Phone Type: ☐ Home ☐ Mobile ☐ Work

Can we leave messages? ☐ Yes ☐ No **What type of message may we leave?** ☐ Basic ☐ Detailed

ADDITIONAL PHONE NUMBER

Is there another phone number we can contact you at? _____

Phone Type: ☐ Home ☐ Mobile ☐ Work

Can we leave messages? ☐ Yes ☐ No **What type of message may we leave?** ☐ Basic ☐ Detailed

HOME ADDRESS

☐ I have stable housing

☐ I have temporary housing

☐ I have unstable housing

What situation best describes your current living situation:

- If you are unsure which housing option to choose, call us, we can help!
- If you have unstable, or temporary housing and do not have a permanent street address, please at least provide us the city, zip, and county of where you normally stay.

☐ Applicant has temporary or unstable housing and does not have other home address documentation and is resident in the State of Arizona.

What is your home street address?
(Don't forget to include your apt., lot#, etc.) _____

City: _____ **State:** _____ **Zip Code:** _____ **AZ County** _____

Is it OK for us to send postal mail to you at this address? ☐ Yes ☐ No If **YES**, skip to **SHIPPING ADDRESS**

MAILING ADDRESS

What is your mailing street address?
(Don't forget to include your apt., lot#, etc.) _____

Mailing City: _____ **Mailing State:** _____ **Mailing Zip Code:** _____

No Mailing Address Acknowledgment ☐ I understand by not providing a mailing address, I must provide an email address to receive notifications, and communications regarding the Ryan White and/or ADAP programs.

SHIPPING ADDRESS

What is your <u>medication only</u>, shipping address?

☐ Same as home address ☐ Same as mailing address ☐ Other address **(list it below)** ☐ No shipping address **(complete acknowledgement below)**

What is your shipping street address?
(Don't forget to include your apt., lot#, etc.) _____

Shipping City: _____ **Shipping State:** _____ **Shipping Zip Code:** _____

No Shipping Address Acknowledgment ☐ I understand by not providing a shipping address, if needed, I must pick up my medications from the approved ADAP pharmacy, in person.

ADDITIONAL QUESTIONS

What is your email address? _____ **May we email you?** ☐ Yes ☐ No

What is the best way to reach you? ☐ Primary Phone ☐ Alternative Contact Person ☐ Mailing Address ☐ Additional Phone ☐ Case manager ☐ Email

List any information you want us to know about how to contact you. _____

CARE TEAM

ALTERNATIVE CONTACT

If we are unable to reach you, is there anyone we can contact to discuss your Ryan White eligibility status? ☐ Yes ☐ No If **NO**, skip to **Case Manager**

Can we leave messages? ☐ Yes ☐ No

What type of message may we leave? ☐ Basic ☐ Detailed

What is this person's name? _____

Do they know about your HIV status? ☐ Yes ☐ No

What is their phone number? _____

What is your relationship to this person? ☐ Partner ☐ Spouse ☐ Child ☐ Parent ☐ Friend

☐ Other _____

CASE MANAGER

Do you have a Ryan White Case Manager? ☐ Yes ☐ No

If no, would you like one? ☐ Yes ☐ No

Who is your Ryan White Case Manager? _____

What Agency do you work with? _____

What is your Case Managers Phone Number? _____

HIV MEDICAL CARE

Where do you get your HIV medical care? _____

☐ I do not have an HIV medical doctor at this time

Who is your HIV doctor? _____

What is their phone number? _____

What is their fax number? _____

Have you ever been in HIV care before? ☐ Yes ☐ No If **YES**, answer the questions below

What is the name of your last HIV doctor? _____

What is their phone Number? _____

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HOUSEHOLD AND INCOME

For this section, we are asking about taxable dependents only. Typically, taxable dependents are your legal spouse, domestic partner, biological/adopted children, or individuals you provide (or who provide you) with 50% or more support. Even if you have not, do not file taxes answer the questions as if you were going to file with the IRS.

- **How many people live in your home, including yourself?** _____

List each person in the table below. ***If you need more space, please complete on a separate sheet of paper and send it in with your application.***

HOUSEHOLD INFORMATION TABLE

	Household Member First Name	Household Member Last Name	Relationship *	Birth Date (MM/DD/YYYY)	Is this person a taxable dependent?	Does this person get money from any source?
1	**Applicant**	**Applicant**	**Self**		☒ Yes ☐ No	☐ Yes ☐ No
2					☐ Yes ☐ No	☐ Yes ☐ No
3					☐ Yes ☐ No	☐ Yes ☐ No
4					☐ Yes ☐ No	☐ Yes ☐ No
5					☐ Yes ☐ No	☐ Yes ☐ No

***If Household Member Relationship = Spouse/Partner, Are you legally married?** ☐ Yes ☐ No

Household Member	What source is this money from?**	Company Name/ source of money?	Date income received last	Gross Amount (before deductions)	How often is money received from this source?			
	List <u>each income source</u> for each household member separately				Weekly	Bi-Weekly (Every 2 weeks)	Semi-Monthly (Twice a month)	Monthly
				$	☐ Weekly	☐ Bi-Weekly	☐ Semi-Monthly	☐ Monthly
				$	☐ Weekly	☐ Bi-Weekly	☐ Semi-Monthly	☐ Monthly
				$	☐ Weekly	☐ Bi-Weekly	☐ Semi-Monthly	☐ Monthly
				$	☐ Weekly	☐ Bi-Weekly	☐ Semi-Monthly	☐ Monthly
				$	☐ Weekly	☐ Bi-Weekly	☐ Semi-Monthly	☐ Monthly

****Source Examples:** Employment, Social Security, Social Security Disability, Veterans Benefits, Self-Employment, Retirement, Pension, Investments, etc.

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HOUSEHOLD AND INCOME (Continued)

For each household member we need documents that support the income source you reported.

Please provide a minimum of **ONE CONSECUTIVE MONTH** of documents, for each income source reported.

- Documents must be issued within the allowable time frames
- Attach copies to this application.

Approved Income Source Documents (submit ALL that apply)
❖ Annual award letter – *Social Security, VA, annual pension, etc.; Current year & valid*
❖ Other award letter – *TANF, Unemployment, etc.; Current period & valid*
❖ 1 month of check stubs – If no check stub received, may submit employer statement.
❖ Current federal tax returns – *filed within the last year and accurately represents the current, expected income*
❖ Proof of current Arizona Health Care Cost Containment System (AHCCCS) enrollment and AHCCCS Data Confirmation form
❖ No Income Attestation – *Included below*
❖ Self-employment records ➢ Most Recent, Complete Federal Tax Returns (filed within the last year and accurately represents the current, expected income) ➢ Minimum of 3 months of profit & loss statements ➢ Other income/expense support documents - *bank statements, credit card statements, receipts, etc.* ➢ Self-Employment/Non-Traditional Income Worksheet & Attestation –*only use if no other documents are available, located at www.azadap.com*
❖ Other income source not listed above

Household Member Name	**No Income Attestation –** Please complete for each household member who reported having no income.
1 _____	☐ I attest that I have no income from any sources listed and I am receiving support from family, friends, or assistance programs to meet my basic needs like food and shelter.
2 _____	☐ I attest, to the best of my knowledge, this household member has no income from any source. They are receiving support from family, friends, or assistance programs to meet their basic needs like food and shelter.
3 _____	☐ I attest, to the best of my knowledge, this household member has no income from any source. They are receiving support from family, friends, or assistance programs to meet their basic needs like food and shelter.
4 _____	☐ I attest, to the best of my knowledge, this household member has no income from any source. They are receiving support from family, friends, or assistance programs to meet their basic needs like food and shelter.
5 _____	☐ I attest, to the best of my knowledge, this household member has no income from any source. They are receiving support from family, friends, or assistance programs to meet their basic needs like food and shelter.

INSURANCE

If you are enrolled into any type of insurance,
please include copies of the front and back of your insurance cards.

OTHER GOVERNMENT HEALTH INSURANCE PROGRAMS

Are you enrolled into Indian Health Services (IHS)? ☐ Yes ☐ No

Are you enrolled into Veterans Affair Services (VA)? ☐ Yes ☐ No

ARIZONA MEDICAID - AHCCCS

Are you currently enrolled in Arizona Medicaid - AHCCCS? ☐ Yes ☐ No

- Depending on your household income, you may qualify for enrollment into Arizona Medicaid. If you appear eligible, but are not enrolled in a Medicaid insurance plan, a staff member will reach out to assist you with applying for enrollment into AHCCCS.

MEDICARE

Are you currently Enrolled into Medicare? ☐ Yes ☐ No

If NO, were you ever enrolled into Medicare Part A, Part B or Part D before, but are not now? ☐ Yes ☐ No

If **YES,** please explain the loss in Medicare coverage. Please be as detailed as possible. If you need more space to explain, please use a separate piece of paper or the Statement of Fact (SOF) form found at www.azadap.com.

_____

_____

_____

If YES, please indicate which Medicare Parts you are enrolled into:

☐ Medicare A ☐ Medicare B ☐ Medicare D

☐ Medicare Advantage Plan ☐ Medicare Supplemental

- Depending on your household income, you may qualify for Social Security's Extra Help with Medicare Prescription Drug Plan Costs. If you appear eligible, but are not receiving an LIS award, a staff member will reach out to assist you with applying for this.
- If you have received Social Security Disability for 24 months, you may be eligible to enroll into Medicare.

EMPLOYER INSURANCE

Are you currently enrolled into Employer provided insurance? ☐ Yes ☐ No

- If you (or your spouse) are employed, and are not enrolled into Medicaid, Medicare, or Employer insurance, we will need information about any insurance plans offered by the employer.
  - If you are **not** enrolled, please submit Summary of coverages, enrollment periods, plan costs, etc., for all health plans offered by the employer. We may also request the employer fill out our Benefit Verification Form (BVF), found at www.azadap.com.
  - If you **are** enrolled, please include the summary of benefits for your plan.

FEDERALLY FACILIATED MARKETPLACE INSURANCE

- If you are enrolled into Medicare or AHCCCS you are not typically eligible for insurance thru the Federally Facilitated Marketplace (FFM)

Are you currently enrolled into Federally Facilitated Marketplace Insurance? ☐ Yes ☐ No

INSURANCE (CONTINUED)

PRIVATE INDIVIDUAL INSURANCE

Are you enrolled into any other health insurance coverage? ☐ Yes ☐ No

If YES, please tell us where this coverage is from:

☐ COBRA ☐ Student Health Plan ☐ Private/Non-Marketplace Plan

☐ Parents Plan ☐ Other: _____

- If you are enrolled, please include the summary of benefits for your plan.

DENTAL INSURANCE

Are you enrolled in any dental insurance other than the Ryan White Delta Dental Program? ☐ Yes ☐ No

If YES, is your dental coverage through a Medicare Policy? ☐ Yes ☐ No

The Ryan White Dental program can help you pay for dental costs.
Do you want to be enrolled into the Ryan White Dental Program if you are eligible? ☐ Yes ☐ No

LOST INSURANCE

Have you lost or expect to lose your insurance in the past/next 60 days? ☐ Yes ☐ No

If YES, what date did this, or is this coverage expected to end? _____

Where was this coverage through? _____

Why did/is this coverage ending? _____

REFERRALS

Have you seen your HIV health provider in the past 6 months?	☐ Yes	☐ No
If NO, would you like a referral?	☐ Yes	☐ No
Have you had lab work done in the past 6 months?	☐ Yes	☐ No
If NO, would you like a referral?	☐ Yes	☐ No
Do you have HIV medications?	☐ Yes	☐ No
If NO, would you like a referral?	☐ Yes	☐ No
Is your ability to provide your daily living needs stable?	☐ Yes	☐ No
If NO, would you like a referral?	☐ Yes	☐ No
Do you have transportation resources to meet your needs?	☐ Yes	☐ No
If NO, would you like a referral?	☐ Yes	☐ No
Do you have issues with stress and/or depression in your life?	☐ Yes	☐ No
If YES, would you like a referral?	☐ Yes	☐ No
Do you have issues with addiction or substance use in your life?	☐ Yes	☐ No
If YES, would you like a referral?	☐ Yes	☐ No

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SUPPORT DOCUMENT GUIDE

Please include any and all document(s) required as well as documents you think will be helpful, even if it is not listed in the examples. Keep in mind, the list of examples are not complete, comprehensive lists. If you are unsure if you should submit something, please call our office at 602-364-3610.

ARIZONA HOME ADDRESS DOCUMENT EXAMPLES

- ☐ Annual award letter - *Social Security, VA, annual pension, etc.; 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 but not limited to: *Letters from Department of Economic Services (DES), Social Security Administration (SSA), Medicare, utility bill, bank statement, other bills, check stubs, etc.*
- ☐ Driver's License, AZ ID Card, or unexpired ADOT Registration – *issued within the last year*
- ☐ Tribal enrollment – *most recent, not expired*
- ☐ US Immigration Identification Card – *most recent, not expired*
- ☐ Proof of current Arizona Health Care Cost Containment System (AHCCCS) enrollment and AHCCCS Data Confirmation form

APPROVED INCOME SOURCE DOCUMENTS

- ☐ Annual award letter - *Social Security, VA, annual pension, etc.; current year & valid*
- ☐ Other award letter - *TANF, Unemployment, etc.; current period & valid*
- ☐ 1 month of check stubs - *if no check stub received, may submit employer statement*
- ☐ Current federal tax returns - *filed within the last year and accurately represents the current, expected income*
- ☐ Proof of current Arizona Health Care Cost Containment System (AHCCCS) enrollment and AHCCCS Data Confirmation form
- ☐ Self-employment records
  - ☐ Most Recent, Complete Federal Tax Returns (filed within the last year and accurately represents the current, expected income)
  - ☐ Minimum of 3 months of profit & loss statements
  - ☐ Other income/expense support documents - Bank statements, Credit Card Statements, receipts, etc.
  - ☐ Self-Employment/Non-Traditional Income Worksheet & Attestation – ***only use if no other documents are available***, located at www.azadap.com
- ☐ Attestation of No Income, *Included in application – page 6*
- ☐ Other income source not listed above

LAB AND DIAGNOSIS DOCUMENTS

Diagnosis documentation is only required for New Applicants

- ☐ Viral Load Lab Results (Copy of Viral Load Lab report drawn within the last 6 months or Medical Provider Page (MPP) if unavailable through HIV Surveillance matching only)
- ☐ Confirmatory documentation
  - ☐ Supplemental testing to confirm diagnosis
  - ☐ Lab report that shows quantifiable viral load was detected
  - ☐ Medical Provider Page (MPP) completed and signed by a clinician with prescribing privileges, located at www.azadap.com
- ☐ Preliminary documentation
  - ☐ Preliminary positive screening test
  - ☐ Copy of antiretroviral therapy prescription

SUPPORT DOCUMENT GUIDE (CONTINUED)

INSURANCE DOCUMENTS THAT MAY BE NEEDED

AHCCCS

- ☐ Current AHCCCS determination letter; approval letter, denial letter **(ALL pages)**
- ☐ Copy of the application for AHCCCS services
- ☐ Copies of AHCCCS Insurance Card

MEDICARE

- ☐ Medicare eligibility/ineligibility letter
- ☐ Confirmation of enrollment into Medicare Part A, Medicare Part B, Medicare Part D, or Advantage Plan
- ☐ Copy of the application for Low Income Subsidy (LIS) for help with Prescription Drug Plan Costs
- ☐ Current Low-Income Subsidy (LIS) determination letter; *approval letter, denial letter reflective of current income levels*
- ☐ Copies of Medicare A/B, Medicare D, Medicare Supplemental, Medicare Advantage insurance cards

EMPLOYER

- ☐ Proof of enrollment
- ☐ Insurance plan information; (for each plan you are enrolled into, or that is offered by an employer)
  - ☐ Summary of benefits
  - ☐ Employee cost of coverages
  - ☐ Enrollment dates/Enrollment period
  - ☐ Enrolled plan effective dates
  - ☐ Prescription/Formulary details
- ☐ Benefit Verification Form(s) (BVF), located at www.azadap.com
- ☐ Employer Coverage Tool(s) (ECT), located at www.healthcare.gov/downloads/employer-coverage-tool.pdf

FEDERALLY FACILIATED MARKETPLACE (FFM)

- ☐ Copy of the FFM eligibility notification, including;
  - ☐ Plan selection
  - ☐ Plan premium cost
  - ☐ Advance Premium Tax Credit (APTC) amount
- ☐ An appeal status/update
- ☐ Affidavit of Understanding for those enrolled into the FFM, located at www.azadap.com
- ☐ Most recent, complete federal tax return (as filed to the IRS) **(ALL pages)**

NEW APPLICANTS ONLY

- ☐ New Applicant Addendum, located at www.azadap.com

OTHER FORMS

- ☐ Statement of Fact (SOF), located at www.azadap.com