

## Arizona Ryan White and ADAP Application

### APPLICANT INFORMATION

<b>Legal Last Name</b>		<b>Legal First Name</b>			<b>MI</b>	
<b>Birth date (month/day/year)</b>			<b>AKA (including maiden &amp; nicknames)</b>			
<b>Self-Identified Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Transgender – Male to Female <input type="checkbox"/> Female <input type="checkbox"/> Transgender – Female to Male			<b>Gender Assigned At Birth</b> <input type="checkbox"/> Male <input type="checkbox"/> Female			
<b>Language Preference</b> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____				<b>Social Security Number (SSN)*</b>		
<b>Home Address</b>		<input type="checkbox"/> Homeless	<b>Apt/Suite#</b>	<b>City</b>	<b>State</b>	<b>Zip Code</b>
						<b>Mail Ok?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Mailing Address (if different than home)</b>			<b>Apt/Suite#</b>	<b>City</b>	<b>State</b>	<b>Zip Code</b>
						<b>Mail Ok?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Initial:</b> I understand that if I do not provide a mailing address, I will <b>NOT</b> receive eligibility notices or mail from my Ryan White _____ service providers. If shipping address is provided below, medications (Rx) <b>ONLY</b> will be shipped to that address.						
<b>Rx Shipping Address (if different than mailing)</b>			<b>Apt/Suite#</b>	<b>City</b>	<b>State</b>	<b>Zip Code</b>
<b>Email Address</b>					<b>OK to E-Mail?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Primary Phone #</b>			<b>Secondary Phone #</b>			
_____			_____			
<b>Type:</b> <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Other <b>OK to leave messages?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			<b>Type:</b> <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Other <b>OK to leave messages?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Alternative Contact Person</b>		<b>Relationship</b>		<b>Phone Number</b>		<b>Aware of Status?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Ryan White Case Manager Name</b>		<b>Agency</b>		<b>Phone Number</b>		<b>Contact instead of client?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Doctor Name</b>		<b>Clinic Name</b>		<b>Phone Number</b>		<b>Fax Number</b>

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

<b>FOR OFFICE USE ONLY</b>						
<b>Application Type:</b>		<input type="checkbox"/> Initial/New	<input type="checkbox"/> Birthday Renewal	<input type="checkbox"/> Birthday Re-Enrollment		
<b>Applicant is applying for:</b>		<input type="checkbox"/> RWPA	<input type="checkbox"/> RWPB	<input type="checkbox"/> RWPC	<input type="checkbox"/> ADAP	<input type="checkbox"/> Dental
<b>Date Received:</b> - - /		<input type="checkbox"/> Logged In/		Assigned Reviewer: _____		
<b>Date Reviewed:</b> - - /		<input type="checkbox"/> Complete		<input type="checkbox"/> Pre-Approved		<input type="checkbox"/> Incomplete
<b>FOR PRE-APPROVED APPLICATIONS</b>						
Pending Documents: DX    \$\$    Labs		AHCCCS Determination		BVF		Other: _____
<input type="checkbox"/> BVF Distributed - - /		<input type="checkbox"/> MPP/Lab Request Sent to: _____ on - - /				
Client Advised of Status & Add. Info Needed on - - / Type: E-Mail    VM    TC    FF						
<b>FOR INCOMPLETE APPLICATIONS</b>						
Missing Documents: DX    \$\$    RES		Other: _____				
Reminder Contact Date: - - /		Type: E-Mail    VM    TC    FF				
Form to be Sent: - - /		Sent: - - /		To be Closed on: - - /		
Missing Documents Received: - - /						
_____ / _____ / _____ / _____ / _____ / _____ / _____ / _____ /						
<b>Date Received</b>		<b>Date Complete</b>		<b>Date Sent to ADAP</b>		<b>Date Entered</b>
						<b>Date Attached</b>

## Arizona Ryan White and ADAP Application

### 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 <b>ONE</b> and attach a copy of documents)
<input type="checkbox"/> Annual income award letter from a government agency or pension - <i>issued for the current year</i>
<input type="checkbox"/> Mortgage, lease/rental agreement, or non-permanent housing letter – <i>most recent, not expired</i>
<input type="checkbox"/> Any Document or mail with the client's name and address – <i>issued within the last 60 days</i> Examples include: DES, Medicare, utility bill, bank statement, other bills, check stubs
<input type="checkbox"/> Driver's License or AZ ID Card – <i>issued within the last year</i>
<input type="checkbox"/> Tribal enrollment, US Immigration Identification Card – <i>most recent, not expired</i>
<input type="checkbox"/> Proof of current Arizona Health Care Cost Containment System (AHCCCS) Enrollment
<input type="checkbox"/> Federal or state tax return showing Arizona residency - <i>filed within the last year</i>
<input type="checkbox"/> Attestations 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 Name

\_\_\_\_\_  
Name of Provider Agency

\_\_\_\_\_  
Staff Member Signature

\_\_\_\_\_  
Date

## Arizona Ryan White and ADAP Application

### INCOME AND HOUSEHOLD SIZE

Please provide **ONE CONSECUTIVE MONTH** of income source documents.

- Documents must be issued within the allowable timeframes.
- **Attach copies to this application.**

INCOME SOURCE DOCUMENTS (check ALL that apply and attach copies)
<input type="checkbox"/> Annual award letter – <i>Social Security, VA, annual pension, etc. ; Current year &amp; valid</i>
<input type="checkbox"/> Other award letter – <i>TANF, Unemployment, etc.; Current period &amp; valid</i>
<input type="checkbox"/> 1 month of check stubs – <i>If no check stub received, may submit employer statement.</i>
<input type="checkbox"/> Self-employment records – <i>only use the Self Employment/Non-Traditional Income Worksheet if other documents not available</i>
<input type="checkbox"/> Current federal tax returns – <i>filed within the last year</i>
<input type="checkbox"/> Proof of current Arizona Health Care Cost Containment System (AHCCCS) enrollment
<input type="checkbox"/> Other income source not listed above – <i>requires Certification of income and/or Support</i>
<input type="checkbox"/> No Income – <i>requires Certification of Income and/or Support</i>

*In the table below, list every family member residing within your household and/or can be claimed as an exemption on your federal tax return (i.e. legal spouse, biological/adopted children, individual you provide more than 50% support for)*

HOUSEHOLD INFORMATION TABLE					
Applicant or Family Member Name	Relationship	Monthly Gross Income	Source	Over age 18?	Claimed on Taxes
<b>Applicant</b>	<b>Self</b>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Household Size</b>	<b>Total Monthly Gross Income</b>		<b>Total Annual Gross Income</b>		

EMPLOYMENT STATUS FOR APPLICANT/ADULT IN THE FAMILY UNIT		
<input type="checkbox"/> Working: _____ hours per week	<input type="checkbox"/> Social Security Disability Insurance (SSDI)	<input type="checkbox"/> Self-Employed
<input type="checkbox"/> Seasonal/Temporary	<input type="checkbox"/> Supplemental Security Income (SSI)	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Full/Part-time college student	<input type="checkbox"/> Unemployed/No Income	
<input type="checkbox"/> Social Security Income (SS)	<input type="checkbox"/> Unemployment Benefits	

CERTIFICATE OF INCOME
I confirm that I am supporting myself in the following manner: (check and complete all that apply)
<input type="checkbox"/> I am homeless or living in a shelter.
<input type="checkbox"/> I am receiving assistance for obtaining food, water, housing, and clothing from: _____ <i>Please attach a letter of support from this person or have this person complete the 'Certificate of Support' below.</i>
<input type="checkbox"/> 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

## Arizona Ryan White and ADAP Application

### MEDICAL/ DENTAL INSURANCE/ OTHER PAYOR

**If you have medical coverage, please attach copies of ALL medical/dental/prescription cards.**

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	
<b>What is your AHCCCS status?</b> <input type="checkbox"/> Enrolled – Plan Name: _____ <div style="display: flex; justify-content: space-between;"> <span>Effective date: ____/____/____</span> <span><input type="checkbox"/> Denied Date: ____/____/____</span> </div> <input type="checkbox"/> Pending – Date applied: ____/____/____ <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <span><input type="checkbox"/> FES Eligible</span> <span>Not Applicable <input type="checkbox"/> Over Income <input type="checkbox"/> Other _____</span> </div>	
FEDERALLY FACILITATED MARKETPLACE (FFM) INSURANCE	
<b>What is your FFM status?</b> <input type="checkbox"/> Enrolled – Plan Name: _____ <div style="display: flex; justify-content: space-between;"> <span>Effective date: ____/____/____</span> <span><input type="checkbox"/> Pending Open Enrollment - Year _____</span> </div> <input type="checkbox"/> Pending – Date applied: ____/____/____ <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <span><input type="checkbox"/> No Special Enrollment Period (SEP)</span> <span><input type="checkbox"/> Not Applicable <input type="checkbox"/> Categorically Ineligible <input type="checkbox"/> Other Coverage</span> </div>	
MEDICARE	
<b>What is your Medicare status?</b> <input type="checkbox"/> Enrolled – Effective Date ____/____/____ <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D Plan Name: _____  <input type="checkbox"/> Medicare Advantage <input type="checkbox"/> Medicare Supplemental                      Plan Name _____                 </div> <div style="width: 50%;"> <b>Will you be eligible for Medicare in the next 12 Months?</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date : ____/____/____  <b>Have you ever been enrolled in Medicare but are not now?</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No Dates of coverage _____ to _____                 </div> </div> <p><b>Not applicable</b> <input type="checkbox"/> &lt;65 <input type="checkbox"/> Not Disabled <input type="checkbox"/> Categorically Ineligible</p> <p><i>If you are enrolled in Medicare, what is your Extra-Help/Low-Income Subsidy?</i>  <input type="checkbox"/> Enrolled - ____% Subsidy <input type="checkbox"/> Pending - Date applied: ____/____/____ <input type="checkbox"/> Denied – Date: ____/____/____</p>	
OTHER GOVERNMENTAL HEALTH INSURANCE PROGRAMS	
Are you eligible for or do you receive health services from Veterans Affairs? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you eligible for or do you receive health services from Indian Health Service? <input type="checkbox"/> Yes <input type="checkbox"/> No
PRIVATE OR EMPLOYER HEALTH INSURANCE	
<input type="checkbox"/> Enrolled Insurance Provider Plan Name: _____ I get insurance from <input type="checkbox"/> My Employer <input type="checkbox"/> Spouse/Domestic Partner or Parent <input type="checkbox"/> Private, Individual Plan <input type="checkbox"/> COBRA Are prescription drugs covered? <input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> I am not enrolled but, can get it from: <input type="checkbox"/> My Employer <input type="checkbox"/> Spouse/Domestic Partner or Parent <input type="checkbox"/> Private, Individual Plan <input type="checkbox"/> COBRA <input type="checkbox"/> I am not eligible to get insurance through my employer, Spouse/Domestic Partner, Parent, or COBRA <b><i>If you and/or your spouse are employed but you do not have employer offered insurance coverage, please have the employer complete the Benefit Verification Form.</i></b>	
DENTAL INSURANCE SCREENING	
Are you eligible for, or enrolled in a dental insurance program other than Ryan White? <input type="checkbox"/> Yes <input type="checkbox"/> No Plan Name: _____ Have you been denied dental insurance by a program you otherwise are eligible for? <input type="checkbox"/> Yes <input type="checkbox"/> No	

### REFERRAL NEEDS

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

## Arizona Ryan White and ADAP Application

### RWPA/B/ADAP/DENTAL ATTESTATION and RELEASE OF INFORMATION

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 or I may not remain in the 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, \_\_\_\_\_ (Client Name), 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 and Partners 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 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 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 abuse 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 signature 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](mailto:ceoffice@aaaphx.org) OR  
**Arizona Department Health Services**, 150 N. 18<sup>th</sup> Ave. Suite 280, Phoenix, AZ. 85007 [careandservices@azdhs.gov](mailto:careandservices@azdhs.gov)

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.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Legal Representative

\_\_\_\_\_  
Relationship to Client

## Arizona Ryan White and ADAP Application

### SUPPORT DOCUMENT GUIDE

#### 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, AHCCCS approval notification, AHCCCS enrollment documentation
  - Medicare card, Medicare enrollment letter
  - Private health insurance card
- AHCCCS Denial – dated within the calendar year (REQUIRED only for clients with income  $\leq$  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 drawn within the last 6 months or Medical Provider Page (MPP) if unavailable through HIV Surveillance matching only)

Income Template (Internal Use Only)

#### REQUIRED SUPPORTING DOCUMENTS – ADAP/RWPB

Medicare Extra Help/LIS Award or Denial Letter dated within the last 2 calendar years  
(REQUIRED only for clients with income  $\leq$  175% FPL)

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

#### REQUIRED SUPPORTING DOCUMENTS – New Applicants Only

New Applicant Addendum

Proof of Diagnosis

#### ADDITIONAL SUPPORTING DOCUMENTS – Required under certain circumstances

Benefit Verification Form

90 Day Medical Provider Override Form

Affidavit of Understanding for individuals enrolled in a Federally Facilitated Marketplace plan

Ryan White Self-Employment/Non-Traditional Worksheet

Statement of Fact