Nevada Ryan White Parts ABCD
Common Guidance Document
Universal Eligibility Application – Six-Month Self-Attestation

Name: _____ **Birth Date:** _____

Mailing Address: _____ **City:** _____ **Zip:** _____

Primary Phone: _____ **Alternate Phone:** _____

If you are returning this form via mail, fax, or email, how would you like to receive confirmation that the agency received this form?
Please be sure the information at the top of page one is up to date.

☐ **Mail** ☐ **Fax** ☐ **Email** ☐ **Phone**

For Administrative Use Only:
New Ryan White Eligibility: Start Date: _____ End Date: _____
Case Manager/ Eligibility Specialist Name: _____

Residency

Since your Annual Certification six months ago, have you moved/changed residence?

☐ No, my address has not changed.
☐ Yes, my address has changed. (*Complete the Residency Section)*

Household Size

Since your Annual Certification six months ago, has your household size changed?

☐ No, there is no change in my household size.
☐ Yes, my household size has changed. (*Complete the Household Size Section)*

Income

Since your Annual Certification six months ago, has your income changed?

☐ No, my income has remained the same.
☐ Yes, my income has changed. *(Complete the Income Section and Attach All Income Documents)*

Health Insurance

Since your Annual Certification six months ago, has your insurance status changed?

☐ No, there is no change in my insurance status.
☐ Yes, my insurance status has changed. *(Complete the Health Insurance Section)*

Since your Annual Certification six months ago, have you become eligible for employer insurance, or marketplace insurance, or Medicaid, or Medicare?

☐ No, has been no change in insurance eligibility
☐ Yes, I have become eligible for health insurance *(Complete the Health Insurance Section)*

Ryan White and Other Service Needs

Are you consistently taking your medications as prescribed?	☐ Yes	☐ No
Do you need counseling or education about your medications?	☐ Yes	☐ No
Do you need counseling or education about Risk Reduction?	☐ Yes	☐ No
Do you have issues with stress and/or depression in your life?	☐ Yes	☐ No

Which Ryan White Services do you need?

☐ Assistance with Food and Meals	☐ Legal Services	☐ Psychosocial Support/ Support Groups
☐ Case Management	☐ Medical Copayment Financial Assistance	☐ Substance Use Therapy
☐ Dental Care	☐ Medical Nutrition Therapy (Dietician)	☐ Transportation Assistance
☐ Emergency Financial Assistance (Utilities, Rent)	☐ Medication Assistance	☐ Treatment Adherence
☐ Health Education/Risk Reduction	☐ Mental Health Therapy	☐ Vision Care
☐ Health Insurance Premium Assistance	☐ Prenatal Care	☐ Other: _____
☐ Housing Assistance	☐ Primary or Specialty Medical Care	☐ Other: _____

AFFIDAVIT

I fully understand that by applying for this program, I am divulging personal information that will be used to assist me with benefits associated with the Nevada Ryan White Parts A, B, C, D Programs. I understand this information will be kept confidential, but will be used by staff to review my eligibility for this program. Also, by signing this form, I understand that the information contained within may be used to verify all application information provided. By applying for this program, I understand that this does not mean that my application will be accepted, as funds are limited and eligibility requirements must be met.

I fully acknowledge:

1. **It is my responsibility to renew my eligibility every 6 months on or before my birth month and 6 months following (half-birth month).**
2. **It is my responsibility to report any changes to my household income, my address, my contact information, my health insurance, or any other information that may affect my eligibility or services.**
3. **If I fail to recertify, my eligibility and benefits will be terminated.**

I certify that the information provided in this application is true and accurate as of the date below and acknowledge that any intentional or negligent misrepresentation of the information may result in nullification of this application and a termination of benefits.

_____	_____	_____
Printed Name	**Signature**	**Date**

You have completed the Six-Month Self Attestation Eligibility Application, *unless* you indicated a change in Residency, Household Size, Income, or Health Insurance on page 1.

On pages 3-5, please complete the sections that you indicated had a change. You do not need to complete any section on pages 3-5 that did not have a change. *If you had a change in Residency or Income, do not forget to attach documentation.*

RESIDENCY

What is your current housing status?

☐ I live in stable housing (includes HOPWA): ☐ Rent ☐ Own ☐ Long-Term Care Facility

☐ I live in temporary housing: ☐ Friends/Family (including couch-surfing) ☐ Hotel/Motel ☐ Transitional Housing or Treatment Center

☐ I live in unstable housing: ☐ Homeless/Emergency Shelter ☐ Jail/Prison/Detention Facility

All clients must provide one (1) residency document from the list below indicating Nevada residency.

- Please select *one* option from the list below and **attach a copy** to this application
- ***If your address changes at any time, please contact an Eligibility Specialist or Case Manager to update your address***
- United States citizenship is **not** a requirement of Ryan White eligibility

Residency Documents	
☐ Current Lease/Rental Agreement	☐ Current Nevada Driver's License or State ID Card
☐ Rent/Mortgage Receipt (dated within the past 30 days)	☐ Consulate Identification Card
☐ Any Bill, Invoice, or Correspondence (dated within the past 30 days)	☐ Resident Alien Card
☐ Paycheck Stubs with Your Address	☐ Proof of Property Taxes Paid
☐ Letter from a Government Agency	☐ Voter Registration/Vehicle Registration
☐ Other Verifiable Government-Issued ID with Address	☐ Prison Release Papers
☐ Dependent Support Form (CGD 15-48) or a Letter: *See below*	☐ I am Homeless: C*omplete the Attestation of Homelessness Below*
☐ Verification of Residence (CGD 15-50) or a Letter from Landlord	
If you cannot provide residency proof in your own name, please complete the Dependent Support Form (CGD 15-48) or submit a letter with your current address and a signature of person(s) providing support.	

Attestation of Homelessness
I attest that I am homeless or living in a shelter with no verifiable residence. I agree that if my residency status changes, I must immediately notify the Ryan White Part All Parts (ABCD) eligibility agency and provide documentation of residency. Client Signature: _____ Date: _____

HOUSEHOLD SIZE

List members of your household, such as a legal spouse and children who live with you, ***and*** anyone you will claim as a dependent on your taxes. *Please list yourself first.*

Client or Family Member Name	Relationship to Client	Does this person have Taxable Income?	Over age 18?	Claimed on Taxes?
	Self	☐ 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	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Total Household Size: _____

INCOME

All clients and household members listed above must provide proof of income documentation from the list below.

- *Please select <u>all</u> income options that apply to your household from the list below and attach copies to this application*
- ***If your income changes at any time, please contact an Eligibility Specialist or Case Manager to update your income***

Income Source Documents
☐ Paycheck Stubs or Employment Statement for the last month *(most recent)*
☐ Annual Award Letter: Social Security, Supplemental Social Security (SSI), Social Security Disability Income (SSDI), Veterans Benefits, Annual Pension, Retirement, etc.
☐ Other Award Letter: Temporary Assistance for Needy Families (TANF), Unemployment, Child support/alimony etc.
☐ One (1) Month of Bank Statements *(only if pay stubs or annual statements cannot be provided)*
☐ Pre-Paid Debit Card Statements
☐ Profit and Loss Statement from Self-Employment (CGD 16-04)
☐ Other Source of Income: _____
☐ No Income: C*omplete the Attestation of No Income Below*

Attestation of No Income

I attest that I have no verifiable income. I agree that if my financial status changes, I must immediately notify the Ryan White Part All Parts (ABCD) eligibility agency and provide documentation of income. I am receiving financial assistance with food, water, and basic needs from:

_____

Client Signature: _____ Date: _____

Non-Taxable Income Sources

Do you, or anyone in your household, have one of the following types of non-taxable income sources?

☐ No, I nor anyone in my household has non-taxable income sources

☐ Yes, I or someone in my household has non-taxable income sources *(check all that apply)*

- ☐ Supplement Social Security Income (SSI)
- ☐ Workers Compensation
- ☐ Child Support Received
- ☐ Veteran's Disability Income
- ☐ Proceeds from Loans (Student/Bank Loans)

Monthly Self $ _____ Monthly Spouse/Household $ _____

Taxable Income Sources

Do you, or anyone in your household, have one of the following types of taxable income sources?

☐ No, I nor anyone in my household has taxable income sources

☐ Yes, I or someone in my household has a taxable income source *(check all that apply)*

- ☐ Wages, Salary, & Tips (Gross- before taxes)
- ☐ Social Security Retirement Income
- ☐ Social Security Disability Income
- ☐ Business / Self Employment Income
- ☐ Taxable Interest and Dividends
- ☐ Capital Gains
- ☐ Rental Income (Net)
- ☐ Unemployment Compensation
- ☐ Taxable amount from Pensions & IRAs Distributions
- ☐ Other income not exempted (Jury Duty Pay, Gambling Winnings)

How often are you or your spouse/household member paid?

Every Week:	☐ Self	☐ Spouse/Household
Every Two Weeks:	☐ Self	☐ Spouse/Household
Semi Monthly- *The 15th and 30th of the Month*:	☐ Self	☐ Spouse/Household
Monthly:	☐ Self	☐ Spouse/Household
Unstable Income:	☐ Self	☐ Spouse/Household

Monthly Self (before taxes) $ _____ Monthly Spouse/Household (before taxes) $ _____

Deductions

Do you, or anyone in your household, have one of the following types of deductions?

☐ No, I nor anyone in my household has deductions

☐ Yes, I or someone in my household has deductions *(check all that apply)*

- ☐ Health Savings Account Deductions
- ☐ Self-Employment Health Insurance Costs
- ☐ Health Costs (Insurance Premiums- Paid by self)
- ☐ Workplace Retirement Plan: 401K
- ☐ Workplace Retirement Plan: 403B
- ☐ Traditional IRA (not a Roth IRA)

Monthly Self $ _____ Monthly Spouse/Household $ _____

FOR ADMINISTRATIVE USE ONLY

Monthly MAGI Income Formula: Monthly Taxable Income Sources minus (-) Monthly Deductions

For taxable income, follow these instructions to calculate monthly MAGI income:

- *If the individual is Paid Every Week, Every Two Weeks, or has Unstable Income: 1) Add the individual's checks together for the 30-day period, 2) Divide that by the number of checks to calculate an average, 3) Multiply the average by, 4.3 if paid weekly, or 2.15 if paid every two weeks. Repeat for each applicable individual (spouse or household member)*
- *If the individual is Paid Semi-Monthly: Add the two amounts together. Repeat for each applicable individual (spouse or household member).*
- *If the individual is Paid Monthly: No calculation is needed.*

Monthly MAGI Income: Self **$ _____** Spouse/Household **$ _____** *Note: (Non-Taxable Income is not included in MAGI)*

Annual MAGI Income: $_____

HEALTH INSURANCE

Select all of the health insurance types you have, then complete all of the sections below:

☐ Medicaid
☐ Medicare Parts A/B/C/D/Supplement
☐ Private- Individual (Direct Purchase/ Marketplace/ COBRA)
☐ Private- Employer
☐ Veterans Health Administration (VA), TRICARE, CHAMPVA
☐ Indian Health Service (IHS)
☐ Other Health Insurance: _____
☐ No Health Insurance

Do you need assistance enrolling in insurance, paying your health insurance premiums, and/or medications? ☐ Yes ☐ No

Medicaid

Are you enrolled in Medicaid?

☐ Yes, I am enrolled in Medicaid Plan Name: _____
☐ I applied, but I was denied. Reason: _____
☐ I applied, but I am awaiting a decision
☐ No, I am not enrolled because:
- ☐ I have other health insurance
- ☐ I am not eligible; my income and assets exceed Medicaid eligibility requirements
- ☐ I need a referral to Medicaid
- ☐ My income is below 138% of the Federal Poverty Level (FPL), but I am declining a referral to Medicaid

Medicare

Are you enrolled in Medicare?

☐ Yes, I am enrolled in Medicare *(check all that apply)*
- ☐ Part A
- ☐ Part B
- ☐ Part C/ Medicare Advantage Plan/ Health Plan Plan Name: _____
- ☐ Part D/ Drug Plan Plan Name: _____
- ☐ Medicare Supplement or Retirement Plan Plan Name: _____

☐ No, I am not enrolled in Medicare

If you are enrolled in Medicare, do you receive Extra Help/ Low-Income Subsidy for your prescription drug costs? ☐ Yes ☐ No

Marketplace/ Nevada Health Link

Are you enrolled in a Marketplace Plan/ Nevada Health Link?

☐ Yes, I am enrolled in a Marketplace Plan/ Nevada Health Link Plan Name: _____
☐ I applied, but I was denied. Reason: _____
☐ I applied, but I am awaiting a decision
☐ No, I am not enrolled because:
- ☐ I have other health insurance
- ☐ I am waiting for the open-enrollment period
- ☐ I need a referral to an insurance specialist for enrollment into a Marketplace Plan
- ☐ My income is between 139% and 400% of the Federal Poverty Level (FPL), but I am declining a referral to the Marketplace

Private or Employer Health Insurance

Are you enrolled in a private or employer based health insurance plan?

☐ Yes, I am enrolled *check all that apply Plan Name: _____
- ☐ Employer Plan
- ☐ COBRA
- ☐ Spouse/ Domestic Partner/ Parent
- ☐ Private- Individual Plan (not Marketplace)

☐ No, I am not enrolled because
- ☐ I have other insurance
- ☐ I am waiting for my employer open-enrollment period
- ☐ I am not employed

☐ No, I am not enrolled, but I may be able to get insurance through: ☐ Employer ☐ Spouse/ Partner/ Parent ☐ COBRA

If you or your spouse are employed and you are requesting premium or prescription assistance, you will be contacted by ADAP staff to complete the Employer Benefit Verification Form.

Nevada Ryan White Parts ABCD
Common Guidance Document
Supplement Document Spacer Form

The following forms are not required, they may be used to meet eligibility criteria for Proof of Diagnosis, Residency, and Income. If you did not use the following documents, please check the first box. If you did use one of the following documents, please check the second box, indicate the form you used, and submit the form(s) with this application.

☐ By checking this box, I certify that I **do not** require the use of any of the following documents:

- 15-48 Dependent Support Form
- 15-50 Verification of Residence
- 16-04 Profit and Loss Statement for Self-Employment

☐ By checking this box, I certify that I **do** require the use of the following document(s):

Please select all that apply

- ☐ 15-48 Dependent Support Form
- ☐ 15-50 Verification of Residence
- ☐ 16-04 Profit and Loss Statement for Self-Employment

Nevada Common Guidance Document
Dependent Support Form

Date: _____

Client Name: _____ DOB: _____

Client Address: _____

If client has no means of support, please indicate the current living arrangement:

☐ Permanent House Guest ☐ Temporary House Guest

☐ Transitional Housing ☐ Other: _____

Do you provide financial assistance for the client, such as assistance with food, water, cash, or basic needs? ☐ Yes ☐ No

The person providing support for the above applicant certifies the following:

I, _____, hereby affirm, under penalty of perjury, that I have been providing support of the person named above and to the best of my knowledge declare that his person has no other primary means of support.

I have provided support (financial or room and board) since: _____

Supporter's Name (please print): _____

Address (if different than above): _____

Telephone Number: _____

Relation to the Client: _____

Supporter's Signature: _____

Nevada Common Guidance Document
Verification of Residence Form

Date: _____

Client Name: _____ DOB: _____

My current physical address: _____
(Street)

_____
(City, State, Zip)

My monthly rent is: $ _____ / per month

My mailing address is: _____
(Street)
(*if different than physical address*)

_____
(City, State, Zip)

I hereby declare that the above information regarding my current living situation is true.

_____ _____
(Client Signature) *(Date)*

I hereby declare that the above information regarding my tenants living situation is true.

_____ _____ _____
(Landlord name – please print) *(Landlord Signature)* *(Date)*

Nevada Ryan White Parts ABCD
Common Guidance Document
Profit and Loss Statement for Self-Employment

Client Name: _____ Date: _____

Company Name: _____

Company Address: _____

Type of Profession: _____

Please fill in the fields that apply to you

GROSS INCOME	
Gross Sales *(Total amount of income from sales or services before subtracting expenses)*	$
Other Income *(Any other additional funds earned through the company such as payments from people leasing space or payments from investors)*	$
Total Gross Income Before Taxes and Expenses	$

EXPENSES	
Cost of Goods Sold- *(Direct costs to produce or obtain the goods sold by the company)*	$
Accounting and Legal Fees	$
Advertising	$
Insurance	$
Maintenance and Repairs	$
Supplies	$
Payroll Expenses- *(Salaries and wages for employees of the company)*	$
Postage	$
Rent	$
Licenses	$
Taxes	$
Telephone	$
Travel/Transportation	$
Utilities	$
Other	$
Other	$
Other	$
Total Expenses	$

NET INCOME	
Gross Income	$
Total Taxes and Expenses	$
Total Net Income (Gross Income Minus Taxes and Expenses)	$

I hereby declare that the above information regarding my personal business income is true.

_____ _____

Client Signature Date