Nevada Ryan White Parts ABCD
Common Guidance Document
Client Change of Information Form

Date of Change: _____

Client Name: _____ **Client URN:** _____

Section I: Residency (Complete only if a change in 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: *Complete 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.	

Acknowledgement

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.

Client Printed Name	Client Signature	Date

Case Manager Printed Name	Case Manager Signature	Date

**In person self-attestations must be signed by the client. Electronic Media attestations must include "signed on behalf of client:" in the client signature.*

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Section II: Household Size (complete only if a change in household)

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: _____

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: _____

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Section III: Income (complete only if a change in income)

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

- *Please select all 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: *Complete 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)	☐ Capital Gains
☐ Social Security Retirement Income	☐ Rental Income (Net)
☐ Social Security Disability Income	☐ Unemployment Compensation
☐ Business / Self Employment Income	☐ Taxable amount from Pensions & IRAs Distributions
☐ Taxable Interest and Dividends	☐ 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	☐ Workplace Retirement Plan: 401K
☐ Self-Employment Health Insurance Costs	☐ Workplace Retirement Plan: 403B
☐ Health Costs (Insurance Premiums- Paid by self)	☐ 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: $_____

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Case Manager Printed Name	**Case Manager Signature**	**Date**

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Section IV: Health Insurance (complete only if change in 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.

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