UNIVERSAL ELIGIBILITY APPLICATIONS UPDATE HIGHLIGHTS

- **Universal Eligibility Application** – is now usable for both Initial and Annual Recertification
- **Six Month Self-Attestation** – is now one page and will be utilized at client's ½ birthday.
- **Client Change of Information Form** – to be utilized whenever a client has a change in income, residency, household size or name change. This form will only be available to case managers and only used if updates are needed.
- **Supplement Forms** – these are forms that will be utilized when client has missing documentation to determine their eligibility. Forms only be available to case managers and only be utilized when necessary.
- All forms are now PDF Fillable

Nevada Ryan White All Parts Common
Guidance Document 18-04A
Universal Eligibility Application

Application Date: _____

☐ **Initial Application** ☐ **Annual Recertification**

One application used for both Initial and Annual Recertification

For Administrative Use Only:

New Ryan White Eligibility: Start Date: _____ End Date: _____

Case Manager/ Eligibility Specialist Name: _____

Subrecipient Agency: _____

New field- agency name where application is being completed

Translator question added

CONTACT INFORMATION

Legal Last Name:	**Legal First Name:**		**Middle Name:**	
***Birth Date:**		**Preferred Name or AKA:**		
Language Preference: ☐ English ☐ Spanish ☐ Other: _____ In Need of a Translator: Yes ☐ No ☐		**SSN or TIN (Optional)**		
Home Address:		**City:**	**State:**	**Zip:**
Mailing Address *(if different than home):*		**City:**	**State:**	**Zip:**
1. Phone – include area code:	**Type:**	**May we contact you by phone?** ☐ Yes ☐ No		
2. Phone – include area code:	**Type:**	**May we leave a message?** ☐ Yes ☐ No		
E-mail Address:	**May we E-Mail you?** ☐ Yes ☐ No	**May we contact you by mail?** ☐ Yes ☐ No		
		Should mail be confidential? ☐ Yes ☐ No		

Minor changes made to these questions

Emergency contact changed to Secondary Contact

SECONDARY CONTACT				
Name:	**1. Phone – include area code:**	**Relation to the Client?**		
Address:	**City:**	**State:**	**Zip:**	
Notes/Comments:	**Is the Secondary Contact Aware of client's status?** ☐ Yes ☐ No			

DEMOGRAPHICS

Added option

***Current Gender Identity:**

- ☐ Male
- ☐ Female
- ☐ Transgender Male-to-Female (MTF)
- ☐ Transgender Female-to-Male (FTM)
- ☐ Transgender Other: _____
- ☐ Refuse to Report (Prefer Not to Disclose)

***Sex at Birth:**

- ☐ Male
- ☐ Female

As shown on Birth Certificate

Clarification added

Preferred Pronouns

Added pronoun field

***Race/Ethnicity:**

- ☐ White
- ☐ Black/African American
- ☐ American Indian/Alaskan Native
- ☐ Native Hawaiian/Pacific Islander (*if checked, choose an option below)*
  - ☐ Native Hawaiian ☐ Guamanian/Chamorro
  - ☐ Samoan ☐ Other Pacific Islander: _____
- ☐ Asian (*if checked, choose an option below)*
  - ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese
  - ☐ Korean ☐ Vietnamese ☐ Other Asian: _____

***Race/Ethnicity:**

- ☐ Non-Hispanic/Latino
- ☐ Hispanic/Latino, (*if checked, choose an option below)*
  - ☐ Mexican, Mexican American, Chicano/a
  - ☐ Puerto Rican
  - ☐ Cuban
  - ☐ Other Hispanic: _____
- ☐ Other: _____

Added option

Relationship Status: ☐ Single ☐ Married ☐ Domestic Partnership ☐ Unmarried Couple ☐ Divorced ☐ Separated ☐ Widowed

Are you a veteran? ☐ Yes ☐ No

Education level questions have been removed

RELEASE OF CONFIDENTIAL INFORMATION

I hereby authorize any of the agencies listed below who participate in the community-based Ryan White All Parts (ABCD) Programs and HOPWA Programs in the State of Nevada to release and/or share information concerning my eligibility, medical record status, and information concerning my diagnosis and treatment. The following agencies/programs authorized are:

- ACCEPT
- Access to Healthcare Network
- Aid for AIDS of Nevada
- AIDS Healthcare Foundation
- Carson City Health and Human Services
- City of Las Vegas
- Clark County Social Service
- Community Counseling Center
- Community Outreach Medical Center
- Dignity Health
- Division of Public and Behavioral Health HIV Surveillance
- Golden Rainbow
- Huntridge Family Clinic
- Kirk Kerkorian School of Medicine / UNLV Health Maternal Child Wellness Program
- Your Health Insurance Company: _____
- Your Physician: _____
- Partner/Spouse/Other: _____
- Impact Exchange
- Magellan Rx – Pharmacy Benefits Manager
- Medicare
- Nevada Division of Welfare and Supportive Services
- Nevada Medicaid
- Northern Nevada HOPES
- Nye County Health & Human Services
- Southern Nevada Health District
- The Gay & Lesbian Center of Southern Nevada
- University Medical Center- Wellness Center
- University Nevada, Las Vegas School of Dental Medicine
- Woman's Development Center

Agency list has been updated

Changed from Affidavit to Acknowledgment

ACKNOWLEDGEMENT

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 suspended.**

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

Nevada Ryan White All Parts
Common Guidance Document 18-06A
Universal Eligibility Application - Six Month Self-Attestation

For Administrative Use Only:
New Ryan White Eligibility: Start Date: _____ End Date: _____

Name:		**Date of birth** ___/___/___

If client's name has changed since your last recertification, please provide supporting documentation (e.g., marriage certificate, divorce decree, Driver's license, Passport, or ID card.)

Address: ☐ **No Change**	***Street:***	***City:***	***State:***	***Zip:***

*If client's residency status has changed since their last recertification, please complete the **Residency Section** of the Client Change of Information Form and include documentation of the change.*

Insurance Status: ☐ **No Change**	☐ **New change as of** (date) _____ ☐ **No form of insurance** ☐ **Medicaid** ☐ **Medicare Part A/AB** ☐ **Medicare Part D**	☐ **ACA health plan** ☐ **Private Insurance** ☐ **VA/CHAMPUS** ☐ **Other (specify):**_____

*If client's insurance status has changed since their last certification, please complete the **Insurance Section** of the Client Information Form and include documentation.*

Income: ☐ **No Change**	☐ **New change as of** (date) _____ ☐ **I/we have no income** ☐ **Work income (increase or decrease)** ☐ **Self-employment income** ☐ **Unemployment Insurance** ☐ **Social Security Income (SSI)** ☐ **Social Security Disability Income (SSDI)**	☐ **Short/Long term disability** ☐ **Pension/retirement income** ☐ **Veterans' benefits** ☐ **Alimony/Child support** ☐ **Stocks, bonds, cash dividends, trust, investment income, royalties** ☐ **Spouse's income** ☐ **Other Income** (List source) _____

*If client's income status has changed since their recertification, please complete the **Income section** of the Client Change of Information Form and include documentation of change).*

Household size: ☐ **No Change**	☐ **New change as of** (date) _____**Current household size**_____

Change of Information Form and include documentation of change.

Client Signature: _____**Date:** _____
I attest that my signature on this form indicates the information provided is accurate and complete to the best of my knowledge.

Staff Signature*: _____**Date:** _____
In person self-attestations must be signed by the client, non-personal attestations must include "Signing for the Client" in the client signature block **AND the signature of the case manager completing the form.*

To be completed by MCM Agency	**Case Manager Name:**	**Subrecipient Agency:**	**Client URN:**

One page document

*No additional paperwork needed if there are no changes

Case manager /Eligibility worker and client both sign

New fields to complete

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.

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: _____

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 <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***

Changed from Affidavit to Acknowledgment

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.*

Nevada Ryan White Parts ABCD
Common Guidance Document
Supplement Document Spacer Form(s)

The following forms may be used to meet eligibility criteria for Proof of Diagnosis, Residency, and Income only when client has no documentation of proof. If any of these documents are utilized case managers will submit the completed forms with the application.

- Request for Proof of Diagnosis- 15-39
- Dependent Support Form- 15-48
- Verification of Residence Form – 15-50
- Profit and Loss Statement for Self-Employment

No changes made to these forms, only use as needed