NEVADA RYAN WHITE UNIVERSAL ELIGIBLITY MANUAL

Updated: April 2023

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INTRODUCTION

Ryan White HIV/AIDS Program (RWHAP) Eligibility

Clients must be determined "eligible" for the Ryan White Program to receive services paid for with federal funds per RWHAP legislation. Eligible clients may qualify to "enroll" in several HIV service and medication assistance programs available across the State of Nevada, and Mojave County, Arizona.

Clients must meet the following eligibility criteria and conditions of eligibility determined by the Ryan White Program, as required by Ryan White legislation.

To be eligible for the Ryan White Program, an applicant must:

1. *Be diagnosed as HIV positive*
2. *Be a resident of Nevada*
3. *Have an individual or household income at or below 400% of the federal poverty level (FPL)*
4. *Be assessed for all other insurance or health care coverage (including Medicaid and Medicare).*

To maintain eligibility for program services, clients must be recertified every six months. At least one of these six-month recertifications within a 12-month period must include collection of supporting documentation similar to that collected at the initial eligibility determination, and one recertification may be completed through "self-attestation". This means that clients who have previously completed a new application or a Full-Year Recert for the prior eligibility period can self-attest, or self-report, that there are no changes to their eligibility criteria they reported on their prior application or recertification. Supporting documentation will only be required if a client reports a change in information since the previous eligibility determination.

Purpose of Manual

The purpose of the Manual is to provide a step-by-step instruction for Subrecipients in completing the Ryan White Universal Eligibility Application (CGD 18-04), 6-Month Self Attestation Form (CGD 18-06) and all additional forms that may be required when determining and maintaining a client's eligibility in the Ryan White Program within throughout the State of Nevada. This Manual will be updated as additional information is developed, and is supplemented by information found on the Ryan White Program Websites at:

Ryan White Part A	Las Vegas TGA	https://lasvegastga.com
Ryan White Part B	End HIV Nevada	https://endhivnevada.org

SIGNING ON BEHALF OF A CLIENT

When a client is either unable or unwilling to sign eligibility documentation, the following written guidance is provided.

I. For clients who are unable to sign documentation, Program staff will be allowed to "sign on behalf of the client" with the client's verbal consent.

Procedure

a. Program staff must print the following words "Signing on Behalf of the Client" in the client signature section. Program staff must then sign their own name and date when the documentation was signed in the proper location.

b. Program staff must annotate the following in the "Comments" section of RWISE/Viewer (Part A) or CAREWare (Part B):

- The reason that client was unable to sign; and
- the date on which the client gave verbal consent.

(Example: "Client was unable to sign eligibility documents due to appointment occurring remotely. On MM/DD/YYYY, the client gave verbal consent allowing STAFF NAME, to sign on their behalf.")

c. Program staff must acquire the client's signature when the client is able to sign the Release of Information (ROI) section of the application, within 14 days of completing eligibility.

d. If a client states that another individual maintains a Power of Attorney on the client's behalf, the proper documentation must be presented, and that individual must sign for the client. A copy of the Power of Attorney must be uploaded into the client's file.

This shall not impact on the client's eligibility to begin receiving services.

II. For clients who refuse to sign proper documentation:

As the Ryan White Program and the Ending the HIV Epidemic Program are voluntary, an individual who refuses to sign proper eligibility documentation will be considered not eligible and therefore will not receive any further services from either program.

Initial/Annual Eligibility Application CGD 18-04

Common Guidance Document – 18-04
Universal Eligibility Application – Brand New Client

Application Date: ____________________ ☐ **Initial Application** ☐ **Annual Recertification**

For Administrative Use Only: New Ryan White Eligibility: Start Date: ______________________ End Date: ______________________ Case Manager/ Eligibility Specialist Name: ____________________________________ Subrecipient Agency: ________________________________

Application Date:

- Date the **complete** application was received by the processing agency.

Initial Application

- Check Initial Application if this is a new or returning client.
- Check Annual Recertification if this is an annual recertification.

Start/End Dates

The Eligibility Start and End dates are determined by the actual birth month of the client.

New Ryan White Eligibility - Start Date:
- The Eligibility Start Date will always be the date the client has completed the eligibility packet.

New Ryan White Eligibility – End Date:
- The Eligibility End Date day will always be the last day of the month.

Notes:
The Case Manager will identify the client's birth date and follow the chart below.

Eligibility Start Date	Eligibility End Date
January 1st – 31st	July 31st
February 1st – 28th	August 31st
March 1st – 31st	September 30th
April 1st – 30th	October 31st
May 1st – 31st	November 30th
June 1st – 30th	December 31st
July 1st – 31st	January 31st
August 1st – 31st	February 28th
September 1st – 30th	March 31st
October 1st – 31st	April 30th
November 1st – 30th	May 31st
December 1st – 31st	June 30th

Gap Certification/Alignment

In order to align a client to birthday/Half-birthday eligibility dates Eligibility Specialist must:

1. Identify the birth month of the client.

2. Identify how many months until the client's birthday. This will be the initial period of eligibility. The table below provides a timeline for enrolling clients. If the client birthday Is less than one month away, they would receive eligibility for just under 7 months (or 6.9999 months of eligibility), if the client's birthday is 2 months away then they would receive only 2 months of eligibility and so on as indicated in the table below:

How many months until the client's birthday?	How long are the initial eligibility period and the gap certification (in months)?
<1	Up to 6.9999
2	2 (gap certification)
3	3 (gap certification)
4	4 (gap certification)
5	5 (gap certification)

3. Count forward how many months are left until the client's birthday from the day you are completing eligibility until their birthday. This is their gap certification.
Example: *Clients completes his/her packet on 9/28/18. A Client has a birthday in October. Since that is less than one month away, the client would receive eligibility from 9/28/2018 to 04/30/2018.*

Case Manager/Eligibility Specialist Name:

- Input the name of the Case Manager/Eligibility Specialist processing the application.

Subrecipient Agency

- Type in the name of the Subrecipient Agency where the application is processed.

COMMENTS:____

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CONTACT INFORMATION

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? Should mail be confidential?	☐ Yes ☐ No ☐ Yes ☐ No

Process

1. Legal Last Name: Fill in with the client's actual LAST name, as provided.
2. Legal First Name: Fill in with the client's actual FIRST name, as provided.
3. Middle Name: Fill in with the Clients actual MIDDLE name, as provided.
4. Birth Date: Use the Drop-Down menu to determine the month, date and year client was born.
5. Preferred Name or AKA: (Optional) Fill in with any known alias, or preferred name, as given.
6. Language Preference: Check if language of choice is English, Spanish, or Other. If other fill in the language identified.
7. In Need of Translator: Check if the client is requesting the need of a translator when meeting with RWPA Subrecipient staff.
8. SSN or TIN: Fill in with clients Social Security Number or other identifier, please read disclaimer that this information is used only to verify Medicaid or Health insurance information. If client does not or unable to provide you with an SSN or TIN put N/A. (optional)
9. Home Address: Home address where client resides. (If client has no address, ensure that client completes the attestation of homelessness).
10. City: Current city that client is living in. (If this is not a Nevada city, client does not qualify)
11. State: Put in Nevada. (Client must be a resident of Nevada to qualify)
12. Zip: Use current (Nevada) Zip Code.
13. Mail Address: Only if different from home address.
14. City: Only if different than (home) Home Address.
15. State: Only if different than (home) State but must still be Nevada.
16. Zip: Only if different than (home) Zip but must still be a Nevada State Zip Code.
17. Phone: Fill in with the client's current primary phone number where client can be reached.
18. Type: Fill in what type of phone it is (cellular, land line etc.)
19. Phone: Fill in with current Secondary phone where they can be reached (Optional)

20. Type: Fill in what type of phone it is (cellular, land line etc.)
21. E-Mail Address: Add in a client's email (if available).
22. May we Email you: Acknowledgment that the case manager can communicate with the client via email.
23. May we contact you by phone: Acknowledgment that the case manager can communicate with the client via telephone.
24. May we leave a message: When a client is not readily available, can the Case worker leave a message for the client at the contact number.
25. May We Contact You by Mail: Does the client give his consent to receive email from the provider.
26. Should mail be confidential: Does the client prefer to have mail from the agency marked as private or confidential?

Notes:

For Emergency Shelters (Trafficking Victims)

- Use client's P.O. Box for mailing address.
- Write "confidential address" on the physical address section and in CAREWare Demographics tab.
- Choose Verification of Residence Form or Letter from Landlord in the residency documents section and attach the letter from the landlord/agency representative.

SECONDARY CONTACT

A secondary contact is the first-person case managers will get in touch with, in a client-related emergency. This information is treated as confidential and is only provided to others on a need-to-know basis.

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		

Process

1. Name: Fill in the First and Last name of the emergency contact identified by the client.
2. Phone: Fill in the telephone number where the emergency contact may be reached.
3. Relation to the Client: What is the relation between the client and their emergency contact.
4. Address: Current address (mailing or physical) of emergency contact.
5. City: Current address of emergency contact.
6. State: Current State where the emergency contact presides.
7. Zip: Current zip code where the emergency contact presides
8. Notes: Has the client given the case manager any special information that the case manager should be made aware of when dealing with client's emergency contact.
9. Aware of status: Is the emergency contact aware of the client's HIV status.

Notes:

- A secondary contact doesn't have to be a close relative or friend. It can be literally anybody.
- If it is truly the case that a client literally doesn’t identify a secondary contact, it's also OK to just not have a secondary contact.
- If the secondary contact does not know the client’s status, it is up to the case manager to keep said status confidential when communicating with the client’s secondary contact.

COMMENTS:____

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DEMOGRAPHICS

Demographic information allows us to better understand certain background characteristics of our clients. This information helps the Ryan White Program communicate effectively with our service community, as well as understand our client(s) varied cultures, which may affect their health.

DEMOGRAPHICS		
***Current Gender Identity:** ☐ Male ☐ Transgender Male-to-Female (MTF) ☐ Female ☐ Transgender Female-to-Male (FTM) ☐ Transgender Other: ______________________ ☐ Refuse to Report (Prefer Not to Disclose)	***Sex at Birth:** ☐ Male ☐ Female As shown on Birth Certificate	**Preferred Pronouns**
***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: ____________________	
Relationship Status: ☐ Single ☐ Married ☐ Domestic Partnership ☐ Unmarried Couple ☐ Divorced ☐ Separated ☐ Widowed		
Are you a veteran? ☐ Yes ☐ No		

Process

1. Current Gender Identity: How does the client currently identify themselves.
2. Sex at Birth: Check the appropriate box of the client's sex at birth.
3. Preferred Pronouns: Fill in with a client's preferred pronoun.
4. Race/Ethnicity: Check the box that client identifies.
5. Relationship Status: Check the choice which the client has identified.
6. Are you a veteran: Is the client a veteran of the US Armed Forces.

COMMENTS:____

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PROOF OF DIAGNOSIS

An applicant is required to have documentation of a medical diagnosis of HIV disease with a laboratory test document confirmed HIV infection for their initial determination of eligibility. **This only has to completed at Initial Eligibility determination.**

PROOF OF DIAGNOSIS (COMPLETED ONLY DURING INITIAL APPLICATION)

All clients must provide upon **initial enrollment only** one (1) medical/legal document from the list below indicating HIV infection. **Documentation must contain the client's full name**. Please select *one* option from the list below and **attach a copy** to this application

Proof of Diagnosis Documents
☐ Western Blot
☐ Letter on physician's letterhead, with signature of doctor, indicating that the applicant is HIV positive with diagnosis date.
☐ Electronic medical record from physician's office, with electronic signature of doctor, indicating that the applicant is HIV positive.
☐ Positive HIV test (immunoassay) and detectable viral load (HIV RNA)
☐ Two positive HIV tests (immunoassays- should be different assays based on different antigens or different principles)
☐ Request for Proof of Diagnosis Form completed by applicant's physician (CGD 15-39)

Process

The Eligibility Specialist will indicate the documentation of confirmed HIV status by checking which documentation was presented for conformation:

1. Western Blot:
2. Letter on physician's Letterhead
3. Electronic medical record from physician's office
4. Positive HIV test (immunoassay)
5. Two positive HIV tests
6. Request for Proof of Diagnosis Form (CGD 15-39)

HIV/AIDS STATUS AND DIAGNOSIS INFORMATION

This only section only need to be completed at the Initial Eligibility determination.

HIV/AIDS STATUS/DIAGNOSIS INFORMATION/RISK FACTORS (COMPLETED ONLY DURING INITIAL APPLICATION)

***HIV/AIDS Status:** ☐ HIV Positive (not AIDS) ☐ HIV Negative (Affected)	☐ HIV Positive (AIDS status unknown) ☐ HIV Indeterminate (infants <2 years old)	☐ CDC Defined AIDS	
***Date of First HIV+ Diagnosis:**	☐ **Estimated?**	***Date of First AIDS Diagnosis:**	☐ **Estimated?**

How do you believe you acquired HIV?

☐ Male to Male sexual contact	☐ Recipient of transfusion of blood, blood components, or tissue
☐ Injection Drug Use	☐ Perinatal Transmission
☐ Male to Female Sexual Contact	☐ Undetermined/Unknown, risk not reported or identified
☐ Hemophilia/Coagulation Disorder	☐ Other, please specify: ______________________

Process

1. HIV/AIDS Status: Check which choice best describes the client's current status:
   - HIV Positive (Not AIDS)
   - HIV Negative (Affected)
   - HIV Positive (AIDS status unknown)

- HIV Indeterminate (infants <2 years old)
- CDC Defined AIDS

2. Date of First HIV+ Diagnosis: Fill in with the date from documents, or if the client has no documentation have the client give an estimated date.
3. Estimated: Check only if the Date of First HIV Diagnosis was estimated by client.
4. Date of First AIDS Diagnosis: Fill in with the date from documents, or if the client has no documentation have the client give an estimated date.
5. Estimated: Check only if the Date of First HIV Diagnosis was estimated by client.
6. How do you believe you contracted HIV: Check which one best applies according to client's comments.

Notes:

- Documentation of HIV-positive status must be reviewed during onsite and/or remote visits and confirmed before initial enrollment by a case manager.

- Any proof of diagnosis document must include the applicant's full, legal name.

- A medical provider may submit a written statement confirming HIV diagnosis, on agency, clinic or public health department letterhead, a prescription pad or medical record is acceptable. All medical providers' electronic medical record with signature is acceptable when warranted.

- A client may also provide a Request for Proof of Diagnosis Form (CGD 15-39).

COMMENTS:____

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BASIC MEDICAL

BASIC MEDICAL	
How do you obtain primary HIV medical care? ☐ Publicly funded clinic or health district ☐ Private Practice ☐ Emergency Room	 ☐ Hospital Outpatient Center ☐ No primary source of care ☐ Other: ___________________
Primary Care Physician Name:	**HIV Specialist Name:**

Process

1. How do you obtain primary HIV medical care: Check whichever is most appropriate to where the client receives their primary HIV medical care.
2. Primary Care Physician Name: Client should identify their primary physician.
3. HIV Specialist Name: Client should identify their HIV Specialist (if different from primary physician).

COMMENTS:____

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RESIDENCY

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

Process

Please check which option best suits the clients described **current** living conditions.

1. <u>Stable Housing</u>
   - Rent: Client is not the primary mortgage holder.
   - Own: Client (or family member) is the primary mortgage holder.
   - Long Term Care Facility: A facility that provides rehabilitative, restorative, and/or ongoing skilled nursing care to patients or residents in need of assistance with activities of daily living.

   <u>Temporary Housing</u>
   - Friend/family (couch surfing):
   - Hotel/Motel
   - Transitional Housing/Treatment Facility: This would include ½ way houses.
2. <u>Unstable Housing</u>
   - Homeless/Emergency Shelter: This would include safe shelters for abuse victims.
   - Jail/Prison/Detention Center (**see Notes below**)

<u>Notes</u>:

- If the client is to be incarcerated for a time period greater than 3 months, they are **not Ryan White eligible**, please refer the client to the Department of Corrections for further assistance.

- If the client is incarcerated (Jail/Prison/Detention Center) at the time and is due to be released within 3 months, refer the client to SNHD's EIS program.

COMMENTS:____

Residency Documents

For eligibility, residency refers to clients who make Nevada their home. A specific number of weeks or months in Nevada are not required to be considered as a resident in Nevada; however, a client's intent to remain in Nevada is of interest, particularly for medical and treatment services All clients must provide one (1) residency document from the list above indicating Nevada residency.

Residency Documentation	
☐ 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.	

Process

Select one (or more) documents that were provided by the client for verification from the list below and attach a copy to the client's application. If the document(s) provided is not listed ensure that residency documentation include the client's name and a listing of a residential address that corresponds with the address given in their application.

- Current State Nevada driver's license or State ID Card
- Housing, rental, or mortgage agreement in client's name
- Any bill, invoice or correspondence dated within 30 days of application.
- Paycheck Stubs
- Bank Statements
- Official correspondence from a Government Agency
- Over verifiable government-issued ID (with corresponding address)
- Consulate Identification Card
- Resident Alien Card
- Property Tax Receipt
- Current Voter Registration
- Vehicle Registration
- Prison Release Papers (if recently released)
- A statement from the shelter in which the client resides or visits (see Attestation of Homelessness)
- A statement from a Social Service agency attesting to the homeless status of the client. (See Attestation of Homelessness)

The following Nevada Common Guidance Document(s) may also be used to establish residency:

- CGD 15-48 Dependent Support Form
- GCD 15-50 Verification of Residence

Notes:

- United States citizenship is not a requirement of Ryan White eligibility.
- Remind client that **IF** their address changes at any time, to contact an Eligibility Specialist or Case Manager to update their address.
- **The residency address may be a PO Box if:**
  1. The recipient has another means to verify the address (such as a utility bill)
  2. If the United States Postal Service (USPS) has not established a residential address for the location. This is often the case on Native American Tribal Reservations.

COMMENTS:____

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Attestation of Homelessness

If a client states that she/he is homeless or lying in a shelter with no verifiable residence, please have them complete the Attestation of Homelessness in the initial and/or annual recertification application.

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: ________________

Process:

1. Client Signature: Have the client sign here.
2. Date: Month, day, and year that this attestation was signed.

COMMENTS:____

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HOUSEHOLD SIZE

A household includes the client, members of his/her family, and certain other adults who live together as a unit. The size of the household assists in determining the client's FPL.

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: ___________

Process

1. Client or Family Member Name: In the first line put in the client, any other family members will follow in the lines below.
2. Relationship to Client: In the first line "self" refers to the client. All others must provide the relationship (wife, son, daughter, etc.) to the client.
3. Does this Person Have Taxable Income? Does the identified relative hold a job or is making any taxable income. Yes or No.
4. Over the age of 18: Is the identified relatives over the age of 18. Yes or No.
5. Claimed on taxes: Is the relative claimed on as part of the CLIENTS' taxes. Yes or no.
6. Total Household Size: Input the number of identified family members, including the client.

Notes:

A dependent is defined by the following is an individual who expects to be or is claimed by the client on their taxes.

A tax dependent assistance unit will be the same as the individual who is claiming them as a dependent, UNLESS:

- They are or expect to be claimed by another Individual who is not a spouse or a biological, adoptive or stepparent.
- They are a child under the age of 19, living with both parents and the parents do not file a joint tax return.
- Or they are a child under age 19 and are being claimed by a non-custodial parent.

If the tax dependent meets one of the above exemptions, they are considered a non-Filer.

Not counted in household size are:

- Roommate(s) with separate finances who share only the cost of room and board. Room and board include household expenses, such as utility, cage, phone, rent or mortgage, and meals.

- Adults, such as a parent, adult siblings, adult children, significant others, and partners who live with the client but have separate finances and/or share only household expenses.
- Live-in aids who receive payment for their services.
- Children who are not financially dependent on the client
- Foster children for whom the client receives foster care income.

NON-FILER

Non-filers are individuals who do not expect to file their own ta return AND meet an exception to the tax dependent rules.

A non-filer Assistance Unit will consist of themselves, and if living in the same home include:

- The individual's spouse.
- Any of their children under age 19.

If a non-filer is under age 19, and if living in the same home include:

- The child's natural, adoptive and stepparent, and
- Any siblings they live with who are under age 19.

NOTE: Anytime there is a change in family composition that results in an increase or decrease in income clients must report this to their Case Managers (proof not required for income sources that remain the same, only for new sources).

COMMENTS:____

INCOME

The Ryan White Program is designed to serve persons at greatest need, so eligibility requires that an individual has low income. For the program in Nevada, eligibility is for those who have a household income that is at or below **400% of the Federal Poverty Level (FPL)**.

Income Source Documentation

Income Source Documentation

Please select *all* income options that apply to your household from the list(s) below.

☐ 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*

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) $** ____________________

Process

Proof of income must be provided for the client and each adult member of his or her household. Adult household members include a spouse and tax dependents.

1. The proof of income must include the payee's name. The following documentation is acceptable in verifying and determining income:

   - Paycheck Stubs or Employment Statements
   - 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 Statement (only if pay stubs or annual statement cannot be provided)
   - Pre-Paid Debit Card Statements
   - Profit and Loss Statement form Self-Employment
   - Other Sources of Income
   - No Income: Complete the Attestation of No Income.

2. The following types of documentation are acceptable Other forms of income verification:

   - Copy of most current year's 1040, or 1040EZ signed by the client.
   - Payroll stubs (2 consecutive stubs) dated within the 30 days before the new/returning application or biannual (twice a year) recertification.
   - Statement from an employer on official company letterhead showing gross pay for the 30-days before the new/returning application or biannual (twice a year) recertification.
   - A letter with current year's date from the department of Social Security Services detailing annual benefits is acceptable as financial proof, if applicable, (e.g., SSI/SSDI letter with current year annual SSI/SSDI financial benefits).

3. <u>How often are you or your spouse/household member paid?</u> Check all that apply.
4. <u>Monthly Self (before taxes)?</u> Calculate the total monthly income derived from the total of Income Sources of the Client.
5. <u>Monthly Spouse/Household (before taxes)?</u> Calculate the total monthly income derived total of Income Sources of the client's spouse and/or household members.

COMMENTS:____

Non-Taxable Income/Unearned Income Sources

Unearned income is all sources of income that are not earned.

Non-Taxable Income Sources

Do you, or anyone in your household, have any 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 - documentation must be provided)*

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

Monthly Self $ ______________________ **Monthly Spouse/Household $**______________________

Process

1. No, I nor anyone in my household, have one of the following types of non-taxable income sources?

    - If the section is checked then no further action is necessary.

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

    - Check all that apply and determine income amounts that client has earned on a monthly basis. Place that amount in the box.

The following are considered non-taxable/

a. Supplement Social Security (SSI)
b. Workers Compensation
c. Child Support Received
d. Veterans Disability Income
e. Proceeds from loans (student/bank loans)

The following are also types of income that are not from employment and must also be documented to determine eligibility. Please make note in the other space.

f. Unemployment Compensation
g. Veterans Pension Benefits
h. Pension or Retirement Benefits
i. Temporary cash Assistance for Needy Families (TANF)

3. Monthly Self: Calculate the total monthly income derived from the total of Income Sources of the Client.

4. Monthly Spouse/Household: Calculate the total monthly income derived from the total of Income Sources of the client's spouse and/or household members.

Notes:

Non-Traditional Income

a. Clients with non-traditional income, that are either self-employed, do not receive a paystub, or are paid in cash, must provide the Profit and Loss Statement for Self-Employment (CGD 16-04). This includes categorically ineligible clients working for cash payment such as day laborers, Las Vegas Strip/Freemont Street entertainers, and sex workers.

Not Considered Income

The following are not to be considered as income sources when determining eligibility:

a. Supplemental Nutrition Assistance Program (SNAP), previously Food Stamps, is not considered income when determining eligibility.
b. Financial Aid, including scholarships and fellowships, received by individuals attending school is not considered income when determining eligibility.
c. One-time payments (for example CARES Act subsidies) are not considered income when determining eligibility.
d. Child Support payments are not considered income when determining eligibility.
e. 401K, if not accessed.
f. Non-accessible income (such as trust funds)
g. Lump-Sum Payments (such as a bonus)

COMMENTS:____

Taxable Income Sources

Taxable Income Sources	
Do you, or anyone in your household, have any 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 – documentation must be provided)*	
☐ 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)
Monthly Self (before taxes) $ ________________	**Monthly Spouse/Household (before taxes) $** ________________

Process

Check the following as appropriate:

1. No, I nor anyone in my household has taxable incomes sources.
   - If a client checks this box, no further action is required.
2. Yes, I or someone in my household has a taxable income source (check all that apply)
   - Check to ensure that all income sources that reported match those documents provided by the client or if they have/are providing documentation matching those items checked.
3. Total the amount of income made earned by client and/or spouse/household member and place monthly amount in appropriate box.

Notes:

Spousal income must be reported and documented for any client who is reported as married. This must be included in the Common Guidance Document (CGD) applications and the documentation requirements are the same as those for the client.

If the couple is legally separated or divorced, this should be noted. In that case, spousal income is not reported, and the spouse is not included in the household size.

COMMENTS:____

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Deductions

Deductions are typically expenses that the taxpayer incurs during the year that can be applied against or subtracted from their gross income when calculating income for eligibility purposes.

Deductions

Do you, or anyone in your household, have any 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 – documentation must be provided)*

☐ 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 (before taxes) $________________ **Monthly Spouse/Household (before taxes) $** __________________

Process

1. No, I nor anyone in my household has deductions.
   - No further action is required.

2. Yes, I or someone in my household has deductions – Check all that apply.
   - Determine who is receiving the amount and inquire on the monthly amount.
   - Calculate the total monthly amount of all deductions and place the amount in the corresponding box.

COMMENTS:

MODIFIED ADJUSTED GROSS INCOME (MAGI)

The Nevada Ryan White Program(s) uses a Modified Adjusted Gross Income (MAGI) to calculate client income. The calculated income is used to identify the client's federal poverty limit. Proof of household income is also based on Modified Adjusted Gross Income (MAGI). Household income includes the client's income and all income of anyone the client claims on their taxes or the income of someone who claims the client is a dependent on their taxes.

Monthly MAGI Income Formula:

- Monthly Income Minus (-) Deductions

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: $________________		

Process

1. **Determine client(s) and spouse/household monthly 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 (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.

   - If the individual is Paid Monthly: No calculation is needed.

2. **Compare client's annual household income to FPL to determine eligibility.**

Circumstances may vary based on the availability of documentation.

If a client's weekly income fluctuates greatly (e.g., day labor),

- Add the individual's checks together for the 30-day period,
- Divide that by the number of checks to calculate an average,
- Multiply the average by 4.3 if paid weekly or 2.15 if paid every two weeks.

- Add the weekly totals together, and then divide by the number of weeks worked to determine the average weekly gross amount.
- Once the average weekly gross amount is determined, use the weekly income calculation above to determine the annual income.

Repeat for each applicable individual (spouse or household member)

Notes:

- Do not include bonuses, holiday pay, commissions and/or overtime, unless it is received on a regular basis or the holiday pay is received in lieu of regular pay (i.e., vacation pay)

- Individuals which, by contract or self-employment, receive their annual income in a period of time shorter than one year shall also have that income averaged over a 12-month period provide the income from the contract is not received on an hourly or piecework basis. (These households may include some school employees, sharecroppers, farmers, and other self-employed households. This does not include migrant or seasonal farm workers.)

COMMENTS:____

MAGI - ASSISTANCE UNIT DETERMINATION (HOUSEHOLD)

Under MAGI the number of assistance units (household members) will depend on how the client expects to file taxes for the year in which eligibility will be determined. Case Managers should identify the related household members and determine their individual tax filing status to determine eligibility. Under IRS rules there are 5 filing status:

- Single
- Married Filing Jointly
- Married Filing Separately
- Head of Household
- Qualifying Widow(er) with Dependent Child

IRS rules state a tax filer's household will include themselves, the joint filer (if applicable) and any dependents they claim on their federal tax return including any tax dependents no living in the home. Use Household Size information provided by the client to determine the filing status of each household member.

Tax Dependent

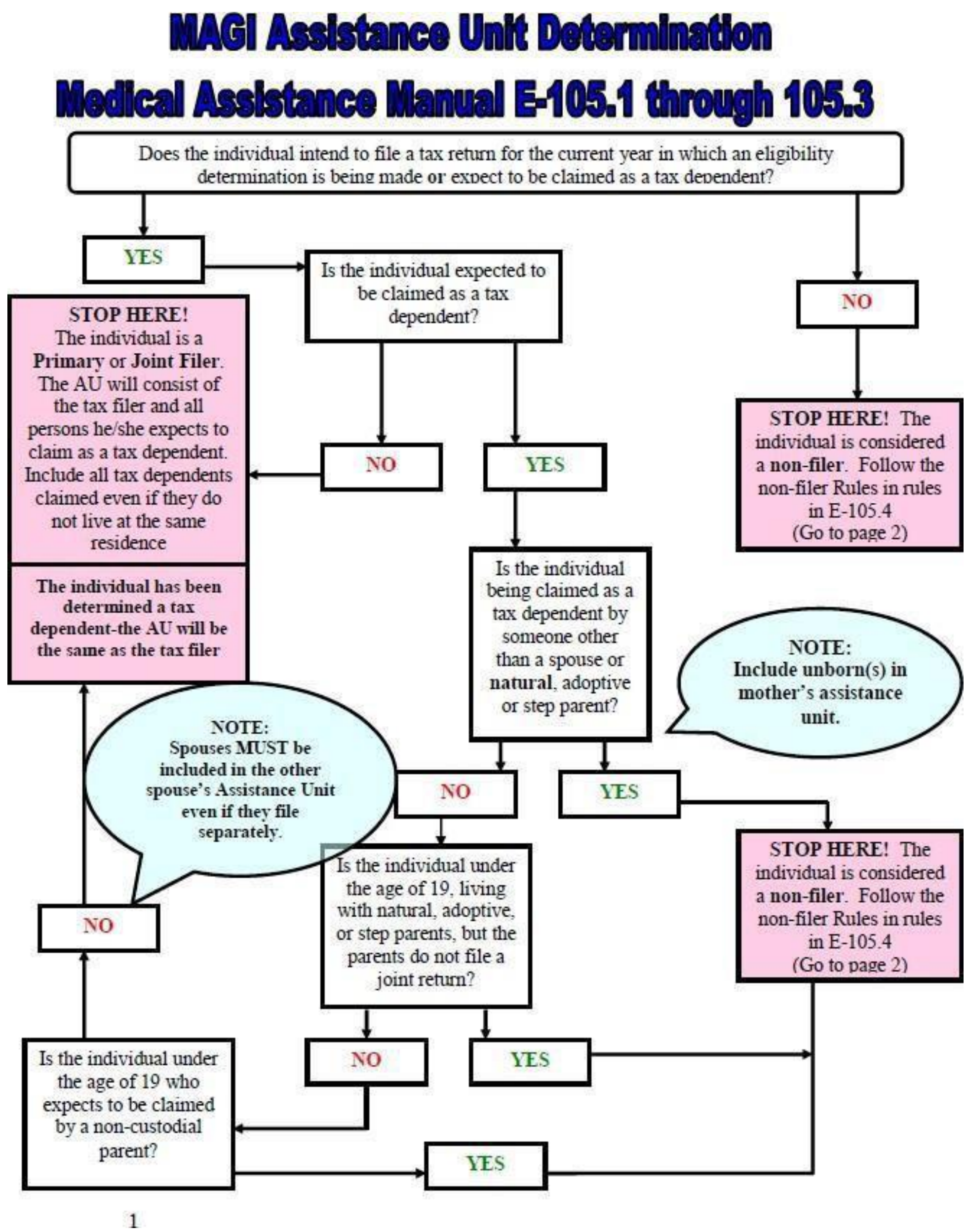
A tax dependent is an individual who expects to be or is claimed as a dependent by another tax filer. A tax dependent's Assistant Unit will be the same as the individual who is claiming them as a dependent unless:

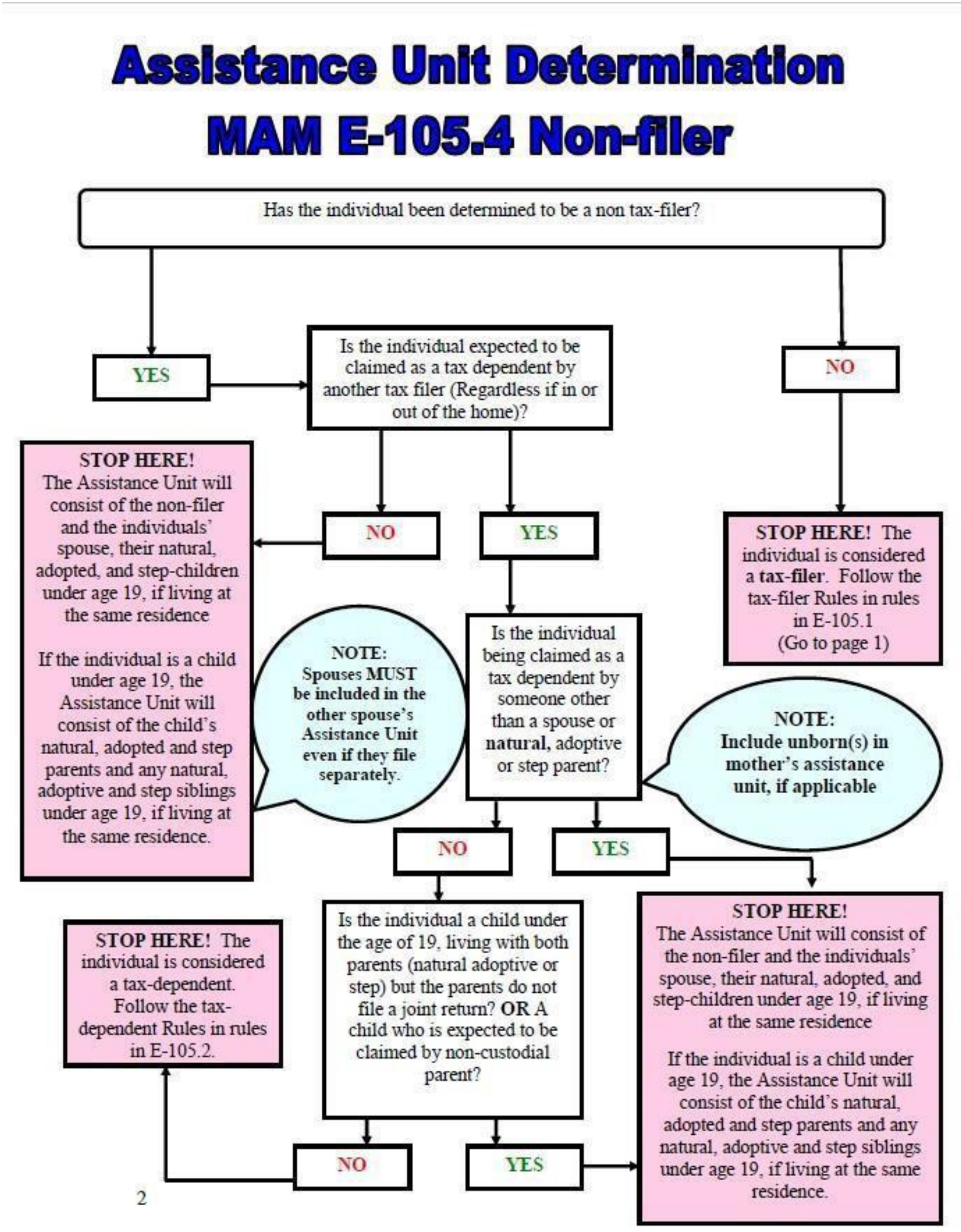
1. They are or expect to be claimed by another individual who is not a spouse or biological, adoptive or stepparent.
2. They are a child under age 19, living with both parents, and the parents do not file a joint tax return.
3. Or they are children under age 19 and are being claimed by a non-custodial parent.

Spouses/Domestic Partners

When determining an individual's assistance unit, spouses/domestic partners must be included in each other's assistance unit. This includes both traditional and same gender couples. It does not matter if they file a joint or separate tax return or if one expects to be claimed as a tax dependent. They must be in each other's assistant unit.

COMMENTS:____


MAGI Assistance Unit Determination
Medical Assistance Manual E-105.1 through 105.3
Does the individual intend to file a tax return for the current year in which an eligibility determination is being made or expect to be claimed as a tax dependent?
YES
Is the individual expected to be claimed as a tax dependent?
NO
STOP HERE! The individual is a Primary or Joint Filer. The AU will consist of the tax filer and all persons he/she expects to claim as a tax dependent. Include all tax dependents claimed even if they do not live at the same residence
NO
YES
STOP HERE! The individual is considered a non-filer. Follow the non-filer Rules in rules in E-105.4 (Go to page 2)
The individual has been determined a tax dependent-the AU will be the same as the tax filer
Is the individual being claimed as a tax dependent by someone other than a spouse or natural, adoptive or step parent?
NOTE: Include unborn(s) in mother's assistance unit.
NOTE: Spouses MUST be included in the other spouse's Assistance Unit even if they file separately.
NO
YES
STOP HERE! The individual is considered a non-filer. Follow the non-filer Rules in rules in E-105.4 (Go to page 2)
Is the individual under the age of 19, living with natural, adoptive, or step parents, but the parents do not file a joint return?
NO
NO
YES
Is the individual under the age of 19 who expects to be claimed by a non-custodial parent?
YES
1



Non-Filer Rules

Non-filers are individual who do not expect to file their own tax return AND meets an exception to the tax expectation rules. A non-filer assistance Unit will consist of themselves, and if living in the same home include:

- The individuals Spouse
- Any of their children under age 19

If the non-filer is under age 19, and if living in the same home include:

- The child's natural, adoptive and stepparent, and
- Any siblings they live with who are underage 19.

COMMENTS:

Attestation of No Income

Clients who state that their household has zero income are required to complete the Attestation of No Income found in the Common Guidance Documents 18-04a New Client Application (English/Spanish), and 18-05a Annual Client Application (English/Spanish) and the no-change in income on the 18-06a.

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: ____________________

Process

1. I am receiving financial assistance with food, water, and basic needs from:
2. The Case Manager should ascertain how client is meeting their basic.
3. Client Signature: Have client sign his/her full name.
4. Date: The date should equal the day that the application was complete.

Notes:

Clients that declare no income must verify other means of support this includes:

- A letter of support from the person(s) providing in-kind support to the client.
- A completed Dependent Support From (CDG 15-48)

COMMENTS:____

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HEALTH INSURANCE

As stated in HRSA PCN #13-05 the Ryan White Program is, "expected to vigorously pursue enrollment into health care coverage for which their clients may be eligible (e.g., Medicaid, CHIP, Medicare, state-funded HIV/AIDS programs, employer-sponsored health insurance coverage, and/or other private health insurance)".

HEALTH INSURANCE	
Do you need assistance enrolling in insurance, paying your health insurance premiums, and/or medications? ☐ Yes ☐ No	
Select all of the health insurance types you have, then complete all of the sections below:	
☐ Medicaid	☐ Veterans' Health Administration (VA), TRICARE, CHAMPVA
☐ Medicare Parts A/B/C/D/Supplement	☐ Indian Health Service (IHS)
☐ Private- Individual (Direct Purchase/ Marketplace/ COBRA)	☐ Other Health Insurance: ____________
☐ Private- Employer	☐ **No Health Insurance**

Determine if client(s) are eligible for insurance. Clients eligible for private marketplace or employer insurance will be required to provide proof of insurance. Sub-recipient(s) are responsible to ensure that clients are screened for other payer sources covered by Federal or State programs such as Medicare and Medicaid., all other forms of insurance or third-party payers (such a private and commercial insurance plans) and other payers.

Medicaid

Medicaid is a state and federally funded entitlement program. The Nevada Department of Children and Families (DCF) and/or the Social Security Administration (SSA) determine Medicaid recipient eligibility. Individuals who might be eligible for Medicaid include:

- Single parent household with children under the age of 18.
- Two parent household unemployed or underemployed.
- Individuals with a disability as determined by the SSA or DCF.

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

Process

Verify if client is enrolled in Medicaid.

1. If yes, check and add the Plan Name, or
2. Check if they have applied and were denied, determine the reason of denial and place reason in box, or
3. Check of client has applied and is awaiting decision, or
4. If the client has not applied, determine the reason why and place a check on any that apply.

Notes:

- Clients who are Medicaid eligible will not be eligible for Ryan White services where the same service is covered by Medicaid. Eligibility staff must verify current Medicaid enrollment.

Medicare

Medicare is a federally funded entitlement program administered by the Centers for Medicare and Medicaid Services. Medicare is health insurance for people aged 65 or older, under age 65 with certain disabilities, or at any age with end-stage renal disease. Most people receive Medicare health coverage in one of two ways: an original Medicare plan (Part A Hospital Insurance or Part B Medical Insurance), or a Medicare Advantage Plan (sometimes referred to as Part C or MA Plans). Medicare Advantage Plans may offer extra coverage, such as vision, hearing, dental, and/or health and wellness programs. Most include Medicare prescription drug coverage (Part D).

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

Process

Verify if the client does or does not have Medicare.

1. If yes, check all that apply –
   Part C/Medicare Advantage Plan/Health plan – Identify the Plan Name
   Part D/Drug Plan – Identify the Plan Name
   Medicare Supplement or Retirement Plan – Identify the Plan Name

2. If no is checked – does the client need assistance in determining if they need additional information to determine if they may qualify. (Refer to Medicare Counselor – AFN)

3. Check the box if they are enrolled in Medicare, check if Yes/No if they ae receiving extra help for prescription drug costs, if no – does the client need assistance in determining if they need additional information to determine if they may quality.

Notes:

- Individuals who are eligible for Medicare must enroll in all coverage that is available before accessing Ryan White Part B services.

- Medicare Part recipients are required to enroll in a drug plan under Part D before accessing NMAP services.

There are two ways to get Medicare Part D prescription drug coverage:

- Join a Medicare Part D prescription drug plan that adds drug coverage to the original Medicare plan; or
- Join a Medicare plan (like an HMO) that includes prescription drug coverage as part of the plan (Part C Advantage Plan).

Marketplace/Nevada Health Link

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

Process

Verify if client is enrolled in Marketplace/Nevada Health Link

1. If yes, check and add the Plan Name, or
2. Check if they have applied and were denied, determine the reason of denial and place reason in box, or
3. Check of client has applied and is awaiting decision, or
4. If client has not applied, determine the reason why and place a check on any that apply.

Private/Employer Health Insurance

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's open-enrollment period.
☐ I am not employed.
☐ No, I am not enrolled, but I may be able to get insurance through: ☐ Employer ☐ Spouse/ Domestic Partner/ Parent ☐ COBRA

Process

Verify if the client has Private/Employer Insurance

1. If yes, check those that apply and add the Plan Name.

2. If not, determine why not and check which applies.

IF THE CLIENT HAS INSURANCE

1. Obtain a copy of the insurance card (front and back) and policy coverage and maintain a copy in eligibility file.
2. Determine if the coverage is viable, including pharmaceutical coverage.
3. Determine the premium cost to the client, and if help is needed with their portion to maintain coverage (not everyone needs assistance with premium payments).
4. If assistance with premium payments is needed, refer to the client (once determined eligible) for HIP CS services.
5. Determine if the client will have access to insurance, and when access will be available (usually there is an open enrollment period).
6. If open enrollment is not immediate, complete the Employer Insurance Verification Form stating the client will have access to insurance during open enrollment and document timeframe.
7. The client must access insurance during open enrollment and provide insurance documentation as specified above.

Notes:

- Refusal to access employer-based insurance is justification to deny eligibility. (Exception: If employer does not accept a third payer)

IF THE CLIENT HAS NO INSURANCE

1. Document steps taken to ensure insurance is not available.
2. Refer the client for NMAP services.
3. If the client is employed but without insurance, the client will need to provide proof that they have no access to insurance from their employer. This can be done in various ways. For example: Letter from employer.

Notes:

- Proper documentation is required. It is not acceptable to take a client's word they have no access to insurance when employed.

COMMENTS:____

Ryan White and Other Service Needs.

The goal is to gather an array of information to develop a comprehensive picture of the clients' needs in order to identify a client's service needs, including barriers that prevent them receiving needed services or from continuing to stay in care.

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: ____________

Process

Assist the client in ascertaining what services are needed.

1. Are you consistently taking your medications as prescribed:
   - If No – try and determine why, please refer client to a subrecipient who provides HERR services.
2. Do you need counseling or education about your medications:
   - If Yes – Please refer client to NMAP for assistance.
3. Do you need counseling or education about Risk Reduction:
   - If Yes – Please refer client to a subrecipient who provides HERR services.
4. Do you have issues with stress and/or depression in your life:
   - If Yes – Please refer client to a subrecipients who provides Mental Health Services

Notes: Make referral to appropriate service provider on behalf of client through CAREWare, or other appropriate means, but follow all confidentiality rules for the protection of the client.

COMMENTS:____

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RIGHTS AND RESPONSIBLITIES

The Rights and Responsibilities statements reflect client's expectations from the program, as well as their responsibilities to the program, as individuals seeking medical and support services from Ryan White All Parts (ABCD) Programs in the State of Nevada.

Client Rights:

ou have the right to request a copy of
es to appeal an agency's decision

Initials: ______________

Client Responsibilities:

ou have the right to request a copy of
es to appeal an agency's decision

Initials: ______________

Process

- Please read (or have the client read) his/her Rights and Responsibilities.

- Have client initial that he/she has read and understands their rights and responsibilities, but only after he/she has acknowledged that they fully understand these rights and responsibilities and their questions and concerns have been answered.

COMMENTS:____

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Release of Confidential Information (ROI)

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:

Process

1. The Case Manager will read or have the client read the above statement and go through the list of current providers.
2. (Optional) The client can fill in the name of their insurance company.
3. (Optional) The client can fill in the name of his physician.
4. (Optional) the client can fill in the name of his partner/spouse/other (this would be preferably his emergency contact)

Information may be released between the above listed agencies throughout the duration of my active enrollment in the Ryan White All Parts (ABCD) program. I may withdraw this consent by notifying, in writing, the Ryan White agency where my eligibility was completed. I understand that my records are protected under federal HIPAA regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I may revoke this consent in writing any time, except to the extent that any action has been taken while it is still in force. This consent expires automatically one (1) year from registration or previously signed consent.

Process

1. Case manager will read or have the client read the above statement.

Notes:

The client cannot choose which agencies he wishes to place on this list, and which to remove. If the question arises, assure the client that **ONLY** those agencies who he/she has sought services from will have access to their information.

COMMENTS:____

ACKNOWLEDGEMENT

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**
______________________________	______________________________	__________
Printed Name of Representative	**Signature of Representative**	**Date**

1. The Case Manager will read or have the client read the statement.
2. The Case Manager will ensure that the client understands the statement prior to client signing.

COMMENTS:____

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Universal Eligibility Application
Six-Month Self- Attestation CGD 18-06

Universal Eligibility Application
Six-Month Self- Attestation
CGD 18-06

Start/End Dates
The Start and End dates are determined by the actual birth month of the client.

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

Process

1. Start Date: The Start Date will always be the date the client has completed the eligibility packet.
2. End Date: The End Date day will always be for 6 months.

Name (Change)

Name:		Date of birth ____/____/________

Process

1. Name: Place the client's full name.
   - Name should match the original Eligibility Application unless there has been a name change.
   - If a 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.).
2. Date of Birth: Complete the client's date of birth (mm/dd/yyyy). Date of birth should match the original Eligibility application.

Change of Address

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

Process:

1. No Change: If no changes have been made check the No Change box.
   - Address should match the previous Eligibility Application.
2. If a 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 Change

Insurance Status: ☐ No Change	☐ New change as of (date) ___________ ☐ No form of insurance ☐ Medicaid ☐ Medicare Part A/AB ☐ Medicare Part C/Medicare Advantage Plan/Health Plan	☐ Medicare Part D ☐ ACA health plan ☐ Private Insurance ☐ VA/CHAMPUS ☐ Other (specify):_______________

Process:

1. <u>No Change</u>: If there is no change to a client's Insurance status, mark the box and no further action is needed.
2. If client's insurance status has changed since their last certification:
   - Check the New Change as of (date) and include the date of the change.
   - Check the type of insurance that the client is now under.
   - Complete the **Insurance Section** of the Client Change of Information Form and include proper documentation.

Change in Income

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) ________

Process

1. **No Change**: If there is no change to a client's Income, mark the box and no further action is needed.
2. If client's income status has changed since their recertification:
   - Check the New change as of (date) and include the date of the change.
   - Check the type of income change that applies.
   - Complete the **Income section** of the Client Change of Information Form and include documentation of change.

Change in Household Size

Household size: ☐ No Change	☐ New change as of (date) ___________Current household size___________

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.*

Process

1. No Change: If there is no change to a clients Household Size, mark the box and no further action is needed.
2. If client's household size has changed since their last recertification,
   - Check the "New change as of" box and add the date of change. Complete the "Current Household Size" by adding the current number of household members.
   - Complete the **Household section** of the Client Change of Information Form and include documentation of change.

Signatures

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.*

Process

Follow the instructions within this section.

Identifier Section

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

Process

1. Case Manager Name: Print the name of the Case Manager completing the form.
2. Subrecipient Agency: Print the Subrecipient agency name where recertification took place.
3. Client URN: Place the client URN in box.

Client Change of Information

Universal Eligibility Application Change of Information

General Data

Date of Change: ____________________

Client Name: ________________________ **Client URN:** ______________________

Process

1. Date of Change: Complete with the date that change occurred.
2. Client Name: Print in the Client's name.
3. Client URN: Place in the Client's URN.

Residency

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.	

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: ____________________

Process

Please review the instructions provided under the Residency Section in the Initial Determination instructions (see Pages 11 – 13).

Household Size

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: ___________________________________

Process

Please review the instructions provided under the Household Section in the Initial Determination instructions (see Pages 14 - 15).

Income

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: $________________

Process

Please review the instructions provided under the Income Section in the Initial Determination instructions (see Pages 16 - 28).

Health Insurance

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.

Process

Please review the instructions provided under the Insurance Section in the Initial Determination instructions (see Pages 29 - 32).

Acknowledgement

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.*

Process
Follow the instructions within this section.

Supplemental Documentation

COMMON GUIDANCE DOCUMENT 15-39
REQUEST FOR PROOF OF DIAGNOSIS

Purpose: This document will be used only when the client has no proof of a Positive HIV Diagnosis as required for eligibility purposes

Client Name ______________________________ DOB: ____________________

The client noted above has requested services from the Ryan White HIV/AIDS Program. The Common Guidance from Ryan White Parts ABCD requires medical verification of diagnosis to determine eligibility for services. This is only at the client's initial enrollment only.

Process

1. Client will fill in their first and last name and/or the name.
2. Client will fill in Date of Birth.

The name and DOB should match the name and DOB given in the eligibility packet.

I hereby give my permission to ____________________ to release the required information to the Ryan White Parts ABCD eligibility providers.

______________________________________ ____________________
Client Signature Date

Process

1. The client will provide the **medical provider's name**.
2. The Client will provide their signature.
3. The Client will provide the date the form was signed.

This section to be completed by your medical provider

DIAGNOSIS INFORMATION

☐ HIV Positive (not AIDS) ☐ CDC defined AIDS
☐ HIV Positive (AIDS Status Unknown) ☐ HIV Indeterminate

HIV Diagnosis Date: ______________ AIDS Diagnosis Date: ______________

If available, please attach client's latest CD4 and Viral Load lab work.

Clinician Printed Name: ______________
Clinician Signature: ______________
License Number: ______________ State Issued: ______________
Telephone Number: ______________ Date: ______________

Process

1. Upon return, Case Manager will ensure that all the information has been completed and if (optional) a copy of the diagnosis was provided.

COMMENTS:____

COMMON GUIDANCE DOCUMENT 15-48
DEPENDENT SUPPORT FORM

Purpose: This form is to be used when a client has no other documentation to meet the Income and or Residency requirement of eligibility. **The form is to be completed by whoever is providing assistance to the client.**

Date: ____________________
Client Name: ______________________________ DOB: ______________
Client Address: ____

Process

1. **Date:** Fill the date the Form was completed
2. **Client Name:** Name of the client should match the eligibility packet.
3. **DOB:** Date of Birth should match that in the eligibility packet.
4. **Client Address:** This would be the address of the individual completing the document, and/or the location where the client is residing.

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

☐ Permanent House Guest ☐ Temporary House Guest
☐ Transitional Housing ☐ Other: ______________________________

Process

1. The best description appropriate to the clients' living situation should be checked.

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

Process

1. The person providing assistance should check Yes or No if they are providing financial or supportive assistance to the client.
2. **IF** financial support is being provided, the case manager should enquire to how much is being provided.

Process

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.

1. **The name of the person providing support will be placed here.**

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: ______________________________

1. The person providing the support should complete this section.
2. Case manager will review the document to ensure completeness.

COMMENTS:______________________________

____

____

____

____

____

COMMON GUIDANCE DOCUMENT 15-50
VERIFICAITON OF RESIDENCE

Purpose: This form is to be used when a client has no other documentation to meet the Residency requirement of eligibility.

Date: ______________________________

Client Name: ____ DOB: ________________

Process

1. **Date:** Dated when the Client has received the form.
2. **Client Name:** Client's name should match that on the eligibility packet.
3. **DOB:** Date of Birth should match that on the edibility packet.

My current physical address: ____
(Street)

____
(City, State, Zip)

My monthly rent is: $ ____ / per month

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

____
(City, State, Zip)

Process

1. **Physical Address:** Address should match that of the eligibility packet.
2. **Monthly Rent:** Exact monthly amount.
    - **No other supporting documentation other than this form is required.**
3. **Mailing Address:** This is completed only if the mailing and physical address are different.

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)*

Process

1. **Client Signature:** Client's signature should match that provided in the eligibly packet.
2. **Date:** Dated prior to/or matches the date Landlord provided.
3. **Landlord Name:** Name of property owner, or authorized individual.
4. **Landlord Signature:** Signature of property owner, or authorized individual.
5. **Date:** Dated when landlord signature was provided.

COMMENTS:____

____

____

____

____

COMMON GUIDANCE DOCUMENT 16-04
PROFIT AND LOSS STATEMENT FOR SELF-EMPLOYMENT

Purpose: This document is to be completed only when the client is:
1) Declaring ownership of a business as his only form of income.
2) Declaring themselves as self-employed in a cash only occupation.

Process

Client Name: ______________________________ Date: __________

Company Name: ______________________________

Company Address: ______________________________

Type of Profession: ______________________________

1. **Client Name:** Name should match that on the eligibility packet.
2. **Date:** Date this form was completed.
3. **Company Name:** Only if one exists, if client is self-employed state **SELF.**
4. **Company Address:** Only if one exists, if client is self-employed, it should match eligibility packet.
5. **Type of Profession**: Enter the type of profession the client is engaged in.

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	$

Process

1. **Gross Sales**: Place in the total amount of income the client has earned within the last 3 months.
2. **Other Income**: Place in the total amount of income made from any other sources in the last 3 months.
3. **Total Gross Income Before Taxes and Expenses**: Place in the total of Gross Sales and Other Income.

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	$

Process

1. Expenses: Place in all amounts of expenses incurred by the client in the last 3 months that best match the description.
2. Total Expenses: Place in the total of amount of expenses identified above.

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

Process

1. **Gross Income**: Place in the total from Gross Income.
2. **Total Taxes and Expenses**: Place in the Total Expenses incurred.
3. **Total Net Income**: Subtract the Total Expense from the Gross Income.

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

Client Signature

Date

Process

1. Client Signature: Have client place his signature here.
2. Date: Have client place the date the document was signed.