



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

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: _____

CONTACT INFORMATION

Legal Last Name:		Legal First Name:		Middle Name:	
*Birth Date:			Preferred Name or AKA:		
Language Preference: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____ In Need of a Translator: Yes <input type="checkbox"/> No <input type="checkbox"/>			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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
2. Phone – include area code:	Type:	May we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No			
E-mail Address:		May we E-Mail you? <input type="checkbox"/> Yes <input type="checkbox"/> No		May we contact you by mail? <input type="checkbox"/> Yes <input type="checkbox"/> No	
				Should mail be confidential? <input type="checkbox"/> Yes <input type="checkbox"/> No	

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? <input type="checkbox"/> Yes <input type="checkbox"/> No		

DEMOGRAPHICS

*Current Gender Identity: <input type="checkbox"/> Male <input type="checkbox"/> Transgender Male-to-Female (MTF) <input type="checkbox"/> Female <input type="checkbox"/> Transgender Female-to-Male (FTM) <input type="checkbox"/> Transgender Other: _____ <input type="checkbox"/> Refuse to Report (Prefer Not to Disclose)		*Sex at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female As shown on Birth Certificate		Preferred Pronouns	
*Race/Ethnicity: <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian/Pacific Islander (if checked, choose an option below) <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian/Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander: _____ <input type="checkbox"/> Asian (if checked, choose an option below) <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian: _____		*Race/Ethnicity: <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Hispanic/Latino, (if checked, choose an option below) <input type="checkbox"/> Mexican, Mexican American, Chicano/a <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Other Hispanic: _____ <input type="checkbox"/> Other: _____			
Relationship Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partnership <input type="checkbox"/> Unmarried Couple <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed					
Are you a veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No					

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

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

*HIV/AIDS Status: <input type="checkbox"/> HIV Positive (not AIDS) <input type="checkbox"/> HIV Positive (AIDS status unknown) <input type="checkbox"/> CDC Defined AIDS <input type="checkbox"/> HIV Negative (Affected) <input type="checkbox"/> HIV Indeterminate (infants <2 years old)			
*Date of First HIV+ Diagnosis:	<input type="checkbox"/> Estimated?	*Date of First AIDS Diagnosis:	<input type="checkbox"/> Estimated?
How do you believe you acquired HIV? <input type="checkbox"/> Male to Male sexual contact <input type="checkbox"/> Recipient of transfusion of blood, blood components, or tissue <input type="checkbox"/> Injection Drug Use <input type="checkbox"/> Perinatal Transmission <input type="checkbox"/> Male to Female Sexual Contact <input type="checkbox"/> Undetermined/Unknown, risk not reported or identified <input type="checkbox"/> Hemophilia/Coagulation Disorder <input type="checkbox"/> Other, please specify: _____			

BASIC MEDICAL

How do you obtain primary HIV medical care? <input type="checkbox"/> Publicly funded clinic or health district <input type="checkbox"/> Hospital Outpatient Center <input type="checkbox"/> Private Practice <input type="checkbox"/> No primary source of care <input type="checkbox"/> Emergency Room <input type="checkbox"/> Other: _____	
Primary Care Physician Name:	HIV Specialist Name:

RESIDENCY

*What is your current housing status? <input type="checkbox"/> I live in stable housing (includes HOPWA): <input type="checkbox"/> Rent <input type="checkbox"/> Own <input type="checkbox"/> Long-Term Care Facility <input type="checkbox"/> I live in temporary housing: <input type="checkbox"/> Friends/Family (including couch-surfing) <input type="checkbox"/> Hotel/Motel <input type="checkbox"/> Transitional Housing or Treatment Center <input type="checkbox"/> I live in unstable housing: <input type="checkbox"/> Homeless/Emergency Shelter <input type="checkbox"/> 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**

Residency Documentation	
<input type="checkbox"/> Current Lease/Rental Agreement <input type="checkbox"/> Rent/Mortgage Receipt (dated within the past 30 days) <input type="checkbox"/> Any Bill, Invoice, or Correspondence (dated within the past 30 days) <input type="checkbox"/> Paycheck Stubs with Your Address <input type="checkbox"/> Letter from a Government Agency <input type="checkbox"/> Other Verifiable Government-Issued ID with Address <input type="checkbox"/> Dependent Support Form (CGD 15-48) or a Letter: <i>See below</i> <input type="checkbox"/> Verification of Residence (CGD 15-50) or a Letter from Landlord	<input type="checkbox"/> Current Nevada Driver’s License or State ID Card <input type="checkbox"/> Consulate Identification Card <input type="checkbox"/> Resident Alien Card <input type="checkbox"/> Proof of Property Taxes Paid <input type="checkbox"/> Voter Registration/Vehicle Registration <input type="checkbox"/> Prison Release Papers <input type="checkbox"/> I am Homeless: <i>Complete the Attestation of Homelessness Below</i>
<i>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.</i>	

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

HOUSEHOLD SIZE

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

Client or Family Member Name	Relationship to Client	Does this person have Taxable Income?	Over age 18?	Claimed on Taxes?
	Self	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Total Household Size: _____

INCOME

Proof of household income is based on Modified Adjusted Gross Income (MAGI). Household income includes all income of anyone the client claims on their taxes or the income of someone who claims the client as a dependent on their taxes.

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

- **If your income changes at any time, please contact an Eligibility Specialist or Case Manager to update your income.**

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: | <input type="checkbox"/> Self | <input type="checkbox"/> Spouse/Household |
| Every Two Weeks: | <input type="checkbox"/> Self | <input type="checkbox"/> Spouse/Household |
| Semi Monthly- <i>The 15th and 30th of the Month</i> : | <input type="checkbox"/> Self | <input type="checkbox"/> Spouse/Household |
| Monthly: | <input type="checkbox"/> Self | <input type="checkbox"/> Spouse/Household |
| Unstable Income: | <input type="checkbox"/> Self | <input type="checkbox"/> Spouse/Household |

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

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 \$ _____

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

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

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*)
- | | |
|--|---|
| <input type="checkbox"/> Health Savings Account Deductions | <input type="checkbox"/> Workplace Retirement Plan: 401K |
| <input type="checkbox"/> Self-Employment Health Insurance Costs | <input type="checkbox"/> Workplace Retirement Plan: 403B |
| <input type="checkbox"/> Health Costs (Insurance Premiums- Paid by Self) | <input type="checkbox"/> Traditional IRA (not a Roth IRA) |

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

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: \$ _____

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: _____

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:

- | | |
|--|---|
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Veterans' Health Administration (VA), TRICARE, CHAMPVA |
| <input type="checkbox"/> Medicare Parts A/B/C/D/Supplement | <input type="checkbox"/> Indian Health Service (IHS) |
| <input type="checkbox"/> Private- Individual (Direct Purchase/ Marketplace/ COBRA) | <input type="checkbox"/> Other Health Insurance: _____ |
| <input type="checkbox"/> Private- Employer | <input type="checkbox"/> No Health Insurance |

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
<p>Are you enrolled in Medicare?</p> <p><input type="checkbox"/> Yes, I am enrolled in Medicare <i>(check all that apply)</i></p> <p style="margin-left: 20px;"><input type="checkbox"/> Part A</p> <p style="margin-left: 20px;"><input type="checkbox"/> Part B</p> <p style="margin-left: 20px;"><input type="checkbox"/> Part C/ Medicare Advantage Plan/ Health Plan Plan Name: _____</p> <p style="margin-left: 20px;"><input type="checkbox"/> Part D/ Drug Plan Plan Name: _____</p> <p style="margin-left: 20px;"><input type="checkbox"/> Medicare Supplement or Retirement Plan Plan Name: _____</p> <p><input type="checkbox"/> No, I am not enrolled in Medicare.</p> <p><input type="checkbox"/> If you are enrolled in Medicare, do you receive Extra Help/ Low-Income Subsidy for your prescription drug costs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Marketplace/ Nevada Health Link
<p>Are you enrolled in a Marketplace Plan/ Nevada Health Link?</p> <p><input type="checkbox"/> Yes, I am enrolled in a Marketplace Plan/ Nevada Health Link Plan Name: _____</p> <p><input type="checkbox"/> I applied, but I was denied. Reason: _____</p> <p><input type="checkbox"/> I applied, but I am awaiting a decision.</p> <p><input type="checkbox"/> No, I am not enrolled because:</p> <p style="margin-left: 20px;"><input type="checkbox"/> I have other health insurance.</p> <p style="margin-left: 20px;"><input type="checkbox"/> I am waiting for the open-enrollment period.</p> <p style="margin-left: 20px;"><input type="checkbox"/> I need a referral to an insurance specialist for enrollment into a Marketplace Plan</p> <p style="margin-left: 20px;"><input type="checkbox"/> My income is between 139% and 400% of the Federal Poverty Level (FPL), but I am declining a referral to the Marketplace</p>

Private or Employer Health Insurance
<p>Are you enrolled in a private or employer-based health insurance plan?</p> <p><input type="checkbox"/> Yes, I am enrolled *check all that apply Plan Name: _____</p> <p style="margin-left: 20px;"><input type="checkbox"/> Employer Plan</p> <p style="margin-left: 20px;"><input type="checkbox"/> COBRA</p> <p style="margin-left: 20px;"><input type="checkbox"/> Spouse/ Domestic Partner/ Parent</p> <p style="margin-left: 20px;"><input type="checkbox"/> Private- Individual Plan (not Marketplace)</p> <p><input type="checkbox"/> No, I am not enrolled because:</p> <p style="margin-left: 20px;"><input type="checkbox"/> I have other insurance.</p> <p style="margin-left: 20px;"><input type="checkbox"/> I am waiting for my employer's open-enrollment period.</p> <p style="margin-left: 20px;"><input type="checkbox"/> I am not employed.</p> <p><input type="checkbox"/> No, I am not enrolled, but I may be able to get insurance through: <input type="checkbox"/> Employer <input type="checkbox"/> Spouse/ Domestic Partner/ Parent <input type="checkbox"/> COBRA</p> <p style="font-size: small; color: #0070c0;"><i>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.</i></p>

RYAN WHITE AND OTHER SERVICE NEEDS		
Are you consistently taking your medications as prescribed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you need counseling or education about your medications?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you need counseling or education about Risk Reduction?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have issues with stress and/or depression in your life?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Which Ryan White Services do you need?		
<input type="checkbox"/> Assistance with Food and Meals	<input type="checkbox"/> Legal Services	<input type="checkbox"/> Psychosocial Support/ Support Groups
<input type="checkbox"/> Case Management	<input type="checkbox"/> Medical Copayment Financial Assistance	<input type="checkbox"/> Substance Use Therapy
<input type="checkbox"/> Dental Care	<input type="checkbox"/> Medical Nutrition Therapy (Dietician)	<input type="checkbox"/> Transportation Assistance
<input type="checkbox"/> Emergency Financial Assistance (Utilities, Rent)	<input type="checkbox"/> Medication Assistance	<input type="checkbox"/> Treatment Adherence
<input type="checkbox"/> Health Education/Risk Reduction	<input type="checkbox"/> Mental Health Therapy	<input type="checkbox"/> Vision Care
<input type="checkbox"/> Health Insurance Premium Assistance	<input type="checkbox"/> Prenatal Care	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Housing Assistance	<input type="checkbox"/> Primary or Specialty Medical Care	<input type="checkbox"/> Other: _____

RIGHTS AND RESPONSIBILITIES

The following statements reflect your rights and responsibilities as an individual seeking medical and support services from Ryan White All Parts (ABCD) Programs in the State of Nevada.

Client Rights

- 1. Respect, Courtesy, and Privacy:** *You have the right to be treated at all times with respect and courtesy within a setting which provides you with the highest degree of privacy possible.*
- 2. Freedom from Discrimination:** *You have the right to freedom from discrimination because of race, color, religion, sex, sexual orientation, gender identity or expression, age, disability, veteran's status, or national origin.*
- 3. Access to HIV/AIDS Service Information:** *You have the right to be informed by your health care and/or social service provider about the full range of available HIV/AIDS treatments and about related available social and support services. You have the right to be advised of the risks and to discuss the benefits of any proposed treatments/services. You have the right to give your informed consent to any treatments/services or services before they are provided.*
- 4. Identity and Provider Credentials:** *You have the right to know the names, titles, specialties, and affiliations of all health and social service providers, and anyone else involved in your care. You have the right to know about the health or social service organization's policies and procedures.*
- 5. Culturally Sensitive Sharing of Information:** *You have the right to have information shared with you in a respectful manner that is easy to understand and takes into account the differences in each person's background, culture, and preferences.*
- 6. Consent and the Care Plan:** *You have the right to be involved in the development of an individualized plan of care prior to and during the course of treatment. You have the right to disagree, change your mind, or request a medical second opinion without affecting the ongoing availability of treatment/services.*
- 7. Choice and Access to Service:** *You have the right to be informed of all available services upon intake. You have the right to choose and receive all treatments/services for which you qualify.*
- 8. Declining Service:** *You have the right to decline treatments/services without pressure from your healthcare or social service provider. You have the right to refuse to participate in any research studies or experiments that the provider may recommend. You have the right to change your mind after refusing or consenting to treatment, clinical trials, counseling, or any other service without affecting ongoing care.*
- 9. Naming an Advocate:** *You have the right to choose an advocate. You may have more than one advocate (such as a family member or another person) to give you support and represent your rights.*
- 10. An Advanced Directive for Care:** *You have the right to have advance directives, such as a Living Will, Healthcare Proxy, or Durable Power of Attorney for health and social services.*
- 11. Access to Financial Information:** *You have the right to ask questions about and see all of your health care bills. You have the right to get referrals and help with any payment problems.*
- 12. Confidentiality and Access to Records:** *You have the right to have all of your records kept strictly confidential, and not released without your permission. You have the right to access all of your records, unless the information is expressly excluded as outlined in HIPAA (Health Insurance Portability and Accountability Act), and to have copies of these at a fair copying cost.*
- 13. Transferred and Continuity of Care:** *You have the right to uninterrupted treatments/services. If possible, your requests to leave one provider and be seen by another should be honored and happen as soon as possible. You may NOT be transferred to another provider or facility without an explanation for the transfer. You must be informed of other options that are available.*
- 14. A Client Grievance Procedure:** *You have the right to voice complaints, to suggest changes, and to be informed about how to file a grievance (a formal written complaint). You have the right to do this without harassment, interference or pressure. You have the right to request a copy of an agency's grievance policy and procedures. You have the right to contact the Ryan White Recipient Offices to appeal an agency's decision about your grievance or at any point should you feel that the agency is not responsive to your grievance.*

Initials: _____

Client Responsibilities

- 1. Respect, Courtesy, and Confidentiality:** *Health and social service providers have the right to be treated with respect and courtesy at all times.*
- 2. Giving Correct and Complete Information:** *You are responsible for giving your provider accurate and complete information; you must give this information to the best of your ability. You are responsible for giving accurate and complete information about third party payers (such as insurance companies, Medicaid, Medicare) to your providers and their facilities*
- 3. Seeking Facts About Your Case:** *You are responsible for asking questions about the care you are receiving if you do not completely understand*
- 4. Following Treatment Plans:** *You are responsible for following treatment plans that you and your providers have agreed upon. You have the responsibility to tell your provider right away if you decide to stop your treatment or go against your provider's advice.*
- 5. Scheduled Appointments:** *You are responsible for keeping appointments that you and your provider have scheduled. If you have to cancel, you are responsible for notifying your provider.*
- 6. Rules and Regulations of Service Provider Organizations:** *You are responsible for following the rules and regulations of your providers and their agencies/facilities.*
- 7. Voicing Complaints and Grievances:** *You are responsible for voicing complaints and presenting grievances in a courteous, appropriate, and timely manner. You should do this by following the provider's grievance policy and procedure, and you may ask for help in doing this if you need it. You are responsible to appeal an agency's decision about your grievance to the Ryan White Recipient Offices or to contact the Recipient Offices if you feel the agency is not responsive to your grievance.*

Initials: _____

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
- ❖ CAN Community Health
- ❖ 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
- ❖ North Country Health Care
- ❖ Project HOME

Information may be released between the above listed agencies throughout the duration of my active enrollment in the Ryan White All Parts (ABCD) program. Only agencies at which I have sought or will seek services will have access to my shared information. 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 or services were rendered while it was or is still in force. I understand that by choosing to withdraw and I am no longer seeking services from Ryan White All Parts (ABCD) program. This consent expires automatically one (1) year from registration or previously signed consent.

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