## Instructions for Utah Ryan White Part B Program Application

(April 2019)

*This application must be completely filled out, signed, and dated. Copies of all the following documents must be included or your application cannot be processed. Please check boxes as you complete the application.*

### 1. Utah Ryan White Part B Programs and Services:

*Enrollment Criteria: Depending on the client's life circumstances, they may qualify for different ADAP services.

| All Clients Must Meet Minimum Eligibility Criteria: HIV+ Utah Resident Low Income | CM | SS | ADAP-M | ADAP-I | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | *Group Plan* | *Medicare* | *COBRA* | *Market-place* | *DPI* |
| **Eligibility** | | | | | | | | |
| Federal Poverty Level (FPL) | 500% FPL | 250% FPL | 250% FPL | 250% FPL | 250% FPL | 250% FPL | 250% FPL | 250% FPL |
| **Services*** | | | | | | | | |
| Non-Medical Case Management | v | v | v | v | v | v | v | v |
| Medical Case Management | v | v | v | v | v | v | v | v |
| Oral Health | | v | v | v | v | v | v | v |
| Emergency Financial Assistance | | v | v | v | v | v | v | v |
| Food Vouchers | | v | v | v | v | v | v | v |
| Transportation | | v | v | v | v | v | v | v |
| Prescriptions | | | v | v | v | v | v | v |
| Outpatient Ambulatory Medical Care | | | v | Not Applicable | Not Applicable | Not Applicable | Not Applicable | Not Applicable |
| Medical Cost Sharing Assistance | | | | v | v | v | v | v |
| Insurance Premiums | | | | | v | v | v | v |

### 2. Proof of Residency Documentation:

*All applicants must provide a copy of at least one of the following documents which features the applicant's name and Utah street address. Documents must not be expired more than two calendar months from submission date unless otherwise specified.*

| Proof of Residency Documentation | Additional Criteria |
|---|---|
| □ Utah Drivers License | *Cannot be expired more than two calendar months* |
| □ Utah State ID | *Cannot be expired more than two calendar months* |
| □ Tribal ID | *Cannot be expired more than two calendar months* |
| □ Paystub or Earning Statement | *Dated within last two calendar months* |
| □ Documents issued by a financial institution | *Bank statement, credit card statement, etc. dated within last two calendar months* |
| □ Current rental or lease agreement | *Signature pages and length of agreement must be included* |
| □ Recent utility bill | *Dated within last two calendar months*<br>*Cell phone bills are not accepted* |
| □ Current mortgage statement | *Dated within last two calendar months* |
| □ Most recent property tax document | *Dated within last 12 months* |
| □ Copy of Social Security Award Letter | *Current year benefit letter* |
| □ Document issued by the State of Utah | *Public assistance documents, tax documents, voter registration cards, vehicle title registration cards, etc. dated within current calendar year or within last two calendar months depending on document* |
| □ Document issued by the United States Federal Government | *Public assistance documents, tax documents, tax transcripts, etc. dated within current calendar year or within last two calendar months depending on document* |
| □ Military/ Veterans Affairs ID | *Cannot be expired more than two calendar months* |
| □ Approved letter from case management agency, homeless shelter, or transitional service provider | *Letter reviewed and approved by UDOH. Letter should be submitted on letterhead, be dated within the last 60 days, and have a signature and contact information* |

**3a. Proof of Income:** Program eligibility is determined from both individual and household income. Clients must meet all of the eligibility criteria as determined by the Program.

- "*Household*" includes the client, the client's legal spouse, and the client's financial dependents including children.
- "*Household income*" includes income earned by the client and the client's legal spouse. Married applicants are required to provide verification of spouse income.
- The Program accepts the **Verification of Employment Form** for individuals who recently gained or lost employment. Provide form to employer to determine gross annual income. *(Verification of Employment Form can be used for Employment Verification and Termination Verification).*
- *Affidavit of Zero Income*: If a client's household receives none of the listed sources of income they may complete the Affidavit of Zero Income.

**3b. Proof of Income:**

The following table provides examples of acceptable documentation for the most common types of income. At a minimum, proof of income documentation must be dated, display the wage earner's name, and sufficient information to determine gross household income.

| Income Type | Acceptable Documentation |
|---|---|
| Wages and salaries from formal employment (wages, tips, commission, etc.) | *One of the following:*<br>□ *The equivalent of one month's earnings dated within two months of submission for ALL jobs. (One month's earnings equals 2 paystubs if paid biweekly or 4 paystubs if paid weekly).*<br>□ *Most recent tax statements or W-2 Forms may be accepted of client is still employed with same company.*<br>□ ***Verification of Employment Form*** *or other Employer Statement displaying current wage, hours worked, pay frequency, and availability of benefits must be signed and dated within two calendar months of submission.* |
| Wages and salaries from informal employment with no paystubs | □ *Depends on source. Work with case management agency to determine most appropriate documentation. The* ***Verification of Employment Form*** *or other Employer Statement may be appropriate.* |
| Self– Employment | □ *IRS Form 1040* ***and*** *Schedule C or Schedule E for most recent tax filing period* |
| Social Security Income | □ *Current year benefit letter* |
| Benefits (Life Insurance, Disability, Educational Assistance, Survivor's, etc.) | □ *Current year benefit letter* |
| Capital Gains, Stocks, Bonds, Cash, Dividends, Trust, Investment Income | □ *Tax Documentation for most recent period or documentation from financial institution* |
| Public Assistance/Unemployment | □ *Unemployment Statement, award letter or paystubs, or General Assistance Letter from DWS for current period* |
| Retirement (Pensions, Annuities, 401k, etc.) | □ *Current benefit statement* |
| Alimony | □ *Current benefit letter or other official documentation* |
| Rental Income | □ *Current rental agreement, tax documentation, or other official documentation* |
| Veterans Benefits | □ *Current year benefit letter* |
| "Other" Income | □ *Depends on source. Work with case management agency to determine most appropriate documentation.* |
| Legal Spouse's Income | □ *See above for acceptable documentation by income type* |

**4. Assessment of Available Coverage:**

The Program defines "vigorously pursue" as making a reasonable effort to enroll a client into health care coverage for which they may be eligible. The ***Verification of Employment and Health Insurance Availability Form*** can be used for Health Insurance Verification.

Reasonable effort should include:

| | |
|---|---|
| □ Assessment of available coverage to the client | □ Assistance in enrolling in health coverage |
| □ Education of the benefits of health insurance | □ Documentation from employer / health insurance verification |

**5. Eligibility Period:**

Once approved, clients are eligible from their eligibility start date through the last day of the sixth month following. The eligibility period is six months of continuous eligibility with a few exceptions: the client is no longer a Utah resident, the client requests to be dis-enrolled, or the client is deceased. Changes potentially impacting eligibility will be determined during the client's next re-certification.

**6. Pharmacy Location:**

The pharmacies where medications are dispensed to eligible ADAP clients are independent of the Utah Ryan White Part B Program. Each pharmacy network and/or individual pharmacy location reserves the right to refuse services to anyone, including eligible ADAP clients. If a pharmacy network or location exercises its' right to refuse services to an eligible ADAP client, that client will be required to receive pharmacy services elsewhere.

**7. Termination:**

It is important to let your *Case Management Agency* know of any changes in your life such as a change in your health insurance, income, address, marital status, household size, and/or housing/living arrangements. If the Program does not know about changes you could lose services or be required to pay back the Program for services you do not qualify for.

Clients will be terminated from Utah Ryan White Part B Program "drug therapy" if they become eligible for coverage under another program or payer source.

Applicants who purposely misrepresent their coverage by health insurance, income and/or any other eligibility determination information may be terminated permanently from the Program, including Core Medical, ADAP-M, ADAP-I, and Supportive Services. If deemed necessary, the Office of the Attorney General may initiate action against such individuals in order to recover costs associated with covering such clients.

**8a. Client and Utah Ryan White Part B Program Rights and Responsibilities:**

*Clients accessing any Utah Ryan White Part B Program (Program) service:*

As a client of the Program, you have the **right**:

- To be treated with respect, dignity, consideration, and compassion.
- To receive services free of discrimination on the basis of race, color, ethnicity, national origin, sex, gender identity, sexual orientation, religion, age, class, physical or mental ability.
- To receive information in terms and language that you can understand, and is culturally appropriate.
- To reach an agreement with your case manager to set an intake assessment and identify the frequency of contact you will have, either in person or over the phone.
- To withdraw your voluntary consent to participate in Case Management services without affecting your medical care or other services for which you are enrolled.
- To be informed about services and options available to you, including the cost.
- To the assurance of confidentiality of all personal information, communication and records.
- To not be subjected to physical, sexual, verbal and/or emotional abuse or threats.
- To file a grievance about services you are receiving or denial of services according to the Case Management Agency's grievance policy.

As a client of the Program, you have the **responsibility**:

- To treat other clients, volunteers, and staff with respect and courtesy.
- To protect the confidentiality of other clients you encounter.
- To be free of alcohol or mind altering drugs while receiving Program services or when on the phone with a service provider.
- To let your case manager know any concerns you have about your case management service plan or changes in your needs.
- To make and keep eligibility and case management appointments.
- To respond to Program communications (calls, letters, etc.).
- To refrain from causing physical, sexual, verbal, or emotional abuse or threats to clients, staff, or volunteers (including pharmacy staff).
- I understand that I am a current resident of Utah and all statements regarding my housing status are true.

I understand the above client rights and responsibilities and I agree to comply with them. I understand that violation of these responsibilities may result in termination from the Program. I understand that I may request and receive a copy of this Policy at any time.

**8b. Client Responsibilities for ADAP Services** (*ADAP-I* and *ADAP-M)*:

**I am applying for Utah Ryan White Part B Program services. By initialing at the end of this authorization, I state that I have read this application and understand the conditions for my participation.**

The Utah Ryan White Part B Program (Program) is helping to pay for my health insurance premiums, deductibles, co-insurance, co-payments or ADAP-Medication Assistance. I understand that I have the following responsibilities in order to continue receiving this help:

- I understand that I am the policyholder of my insurance plan being paid for by the Program and I have the responsibility of sharing any letters, bills, and communication I receive from the insurance company with my case manager or benefits specialist.
- I understand if I do not re-certify every six months I am considered ineligible for the Program and I am responsible for paying back any Program money spent on my insurance during the time I did not recertify, which may include monthly premiums, deductibles, co-insurance, and/or co-payments.
- I understand that if I receive a refund check from the insurance company that I have the responsibility to return this money to the Program. I understand that if I do not make payment arrangements with the Program I will not be eligible to continue receiving Program services.
- I understand that if I receive a refund on my tax returns due to underpayment of premium tax credits through the Health Insurance Marketplace that I have the responsibility to return this money to the Program. I understand that if I do not make payment arrangements with the Program I will not be eligible to continue receiving Program services.
- I understand that if I do owe the Program any money due to insurance over-payment, failure to re-certify every six months, due to underpayment of premium tax credits on the Marketplace, or other reasons then I can enter into a payment plan to continue receiving help from the Program.
- The Program **will not** help you pay any penalties for not being enrolled in health insurance. You will have to pay any penalties yourself. Under the Affordable Care Act (ACA), the federal tax penalty for not having health insurance in 2018 was $695 per person or 2.5% of your yearly household income, whichever was more. Some people may be exempt from penalties (not have to pay). For example, if you do not make enough money to file a tax return, you may be exempt from penalties.
- If you do not have health insurance and are enrolled in ADAP-M, then you will only be able to get medications listed on the ADAP-M Formulary and only be able to see Program-contracted doctors and providers.
- I understand that I have the responsibility to re-certify with the Program every six months or I risk having my services cancelled.
- I understand it is my responsibility to stay in communication with my case manager / benefits specialist by immediately informing them of changes in my health, income, health insurance, residency, address, phone number, marital status, household size, and/or housing / living arrangements and by responding to my case manager's / benefits specialist's communications (calls, letters, etc.) to the best of my ability.
- I understand that I am a current resident of Utah and all statements regarding my housing status are true.

**Client Initials: _____ Date: _____** **Case Manager/Benefits Specialist Initials: _____ Date: _____**

**9. How to Submit Your Application:**

It is important to let your *Case Management Agency* know of any changes in you life such as a change in your health insurance, income, address, marital status, household size, and/or housing / living arrangements. If the Program does not know about changes you could lose services or be required to pay back the Program for services you do not qualify for. It is best to work with your Case Management Agency to re-certify, but if you prefer to re-certify on your own, the forms are available online at http://health.utah.gov/epi/treatment/. **If you choose to re-certify on your own, please submit a complete Re-certification Form with all required documents to your Case Management Agency. *Additional documentation may be required.***

| Clinic 1A University of Utah | Utah AIDS Foundation | Utah Department of Health |
|---|---|---|
| Mail: 30 North 1900 East<br>RM: 4B319<br>Salt Lake City, UT 84132<br>ATTN: Amanda Sanchez | Mail: 1408 South 1100 East<br>Salt Lake City, UT 84105 | Mail: Box 142104<br>Salt Lake City, UT 84114 |
| Phone: (801) 585-2670 | Phone: (801) 487-2323 | Phone: (801) 538-6197 |
| Fax: (801) 581-6853 | Fax: (801) 486-3978 | Fax: (801) 536-0978 |

# Utah Ryan White Part B Program Application Form (*April 2019*)

**Office Use Only:** CM Agency: ☐ C1A ☐ UAF ☐ UDOH Assisted with Application:_____
Contact for Follow-Up:_____

Check applicable service(s):
☐ DPI ☐ MP ☐ Employer ☐ COBRA ☐ Medicare Co-Pay ☐ Medicare Premium & Co-Pay ☐ ADAP-M ☐ SS ☐ CM Only

Application Reason *select one or more*:
☐ Establishing Care ☐ Lost Medicaid ☐ Seeking Supportive Service(s)
☐ New to Medications ☐ Newly Unemployed ☐ Other_____
☐ New Diagnosis ☐ Previously Over Income _____
☐ New to Utah ☐ Recently Released from Prison _____

☐ Request to Expedite by: ____/____/____

**1. Applicant Information** Date of Birth:____/____/_____ C1A MRN:_____ ☐ UAF Not Applicable

Legal Name (Last, First, Middle):_____ Sex at Birth: ☐ Male ☐ Female

Preferred Name:_____ Social Security #:_____-_____-_____ ☐ NA ☐ Refused

Current Gender: ☐ Male ☐ Female ☐ Transgender (Male to Female) ☐ Transgender (Female to Male) ☐ Refused

Race *select one or more:* ☐ White ☐ Black or African American ☐ Asian
☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander

Ethnicity *select one:* ☐ Non-Hispanic / Latino/a or Spanish origin ☐ Hispanic / Latino/a or Spanish origin

Race & Ethnicity Subgroups *select one or more:*

| ☐ These race and ethnicity subgroups do not apply to me. | ☐ Hispanic: | ☐ Asian: | | ☐ Native Hawaiian or Other Pacific Islander: |
|---|---|---|---|---|
| | ☐ Mexican, Chicano/a | ☐ Asian Indian | ☐ Korean | ☐ Native Hawaiian |
| | ☐ Puerto Rican | ☐ Chinese | ☐ Vietnamese | ☐ Guamanian or Chamorro |
| | ☐ Cuban | ☐ Filipino | ☐ Other Asian | ☐ Samoan |
| | ☐ Other Hispanic | ☐ Japanese | | ☐ Other Pacific Islander |

**2. Applicant Contact Information** ☐ Do not contact me by mail

Physical Address: Street:_____ Apt #:_____

City:_____ County:_____ State:_____ ZIP:_____

Mailing Address *(If different from Physical Address):* Street or PO Box_____

Apt #:_____ City:_____ State:_____ ZIP:_____

Preferred Phone #:_____ E-mail:_____

The Program has my permission to text and/or e-mail me: ☐ Yes ☐ No

**3. HIV Status** *To be completed by Medical Provider*

Provider Name:_____ Will patient be prescribed ART? ☐ Yes ☐ No

HIV Status: ☐ HIV+, not AIDS ☐ HIV+, AIDS status unknown ☐ CDC-defined AIDS ☐ HIV Indeterminate (infants < 2 yrs)

HIV+ Diagnosis Date: ____/____/_____(mm/dd/yyyy) AIDS Diagnosis Date: ____/_____/_____(mm/dd/yyyy)

Initial Risk Factor(s) for HIV Infection *select one or more*:
☐ Male who has sex with male(s) ☐ Hemophilia/coagulation disorder ☐ Receipt of transfusion of blood, blood components, or tissue
☐ Injection drug use ☐ Perinatal transmission
☐ Heterosexual contact ☐ Not reported or not identified

Provider Signature:_____ Date:_____

**4. Proof of Utah Residency**

*Submit <u>at least one</u> of the following documents that features **your name and your Utah street address.***

- Utah Driver's License
- Utah State ID
- Tribal ID
- Paystubs or Earning Statement
- Documents issued by a financial institution
- Current rental or lease agreement
- Recent utility bill
- Current mortgage statement
- Most recent property tax document
- Copy of Social Security Award Letter
- Document issued by the United States Federal Government
- Document issued by the State of Utah
- Military/Veteran's Affairs ID
- Residency Verification Form

**5. Housing Status** □ Stable Permanent Housing □ Temporary Housing □ Unstable Housing

**6. Household Size & Marital Status**

Married: □ Yes □ No Household Size:_____

□ I am separated, and I receive no financial support from my spouse

*List other persons in household. Include all other adults and children.*

| Name (First Last) | Relationship | Age |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**7. Proof of Income**

□ *AFFIDAVIT OF ZERO INCOME*

I hereby attest that my household is not currently receiving or expecting to receive any of the income types listed below.

How do you pay for your financial obligations? _____

_____

_____

*INSTRUCTIONS*

Monthly amount must be indicated for each type of income, even if the amount is $0. Blank monthly amounts are unacceptable. The income type(s) and monthly amount(s) indicated below must match what is reported elsewhere on this application form to serve as income verification. **Refer to "Instructions for Utah Ryan White Part B Program Application" for acceptable documentation to verify income.**

| **Type of Income** | **Applicant: Check "yes" or "no" for each source** | **Gross Monthly Income** | **Spouse: Check "yes" or "no" for each source** □ ***Not Married*** □ ***I'm separated; I receive no financial support from my spouse*** | **Gross Monthly Income** |
|---|---|---|---|---|
| Wages and salaries from formal employment (*Wages, Tips, Commission, etc.)* | □ Yes □ No | $ _____ | □ Yes □ No | $ _____ |
| Wages and salaries from informal employment with no paystubs | □ Yes □ No | $ _____ | □ Yes □ No | $ _____ |
| Self-Employment | □ Yes □ No | $ _____ | □ Yes □ No | $ _____ |
| Social Security Income | □ Yes □ No | $ _____ | □ Yes □ No | $ _____ |
| Benefits (*Life insurance, Disability, Educational Assistance, Survivor's, etc.*) | □ Yes □ No | $ _____ | □ Yes □ No | $ _____ |
| Capital Gains, Stocks, Bonds, Cash, Dividends, Trust, Investment Income | □ Yes □ No | $ _____ | □ Yes □ No | $ _____ |
| Public Assistance / Unemployment | □ Yes □ No | $ _____ | □ Yes □ No | $ _____ |
| Retirement (*Pensions, Annuities, 401k, etc.*) | □ Yes □ No | $ _____ | □ Yes □ No | $ _____ |
| Alimony | □ Yes □ No | $ _____ | □ Yes □ No | $ _____ |
| Rental Income | □ Yes □ No | $ _____ | □ Yes □ No | $ _____ |
| Veterans Benefits | □ Yes □ No | $ _____ | □ Yes □ No | $ _____ |
| "Other" Income | □ Yes □ No | $ _____ | □ Yes □ No | $ _____ |
| **Do you work 30 or more hours per week?** | **□ Yes □ No** | | **□ Yes □ No** | |

**8. Health Insurance**

*Select all of the health insurance types you have:*

□ Private-Individual (DPI / COBRA / MP)
□ Private-Employer or other Group Plan
□ Medicare Part A/B
□ Medicare Part D or other Medicare pharmacy coverage
□ Medicaid, Children's Health Insurance Program (CHIP), or other public plan
□ Veterans Health Administration (VA), Tricare or other military health care
□ Indian Health Services (IHS)
□ Other Plan: _____

□ No health insurance / uninsured:
- □ I decline health insurance available to me.
- □ Open enrollment is currently closed and I have not had and do not foresee having a qualifying life event. I will enroll during next open enrollment.
- □ It is currently open enrollment and I need medications while pursuing health insurance (*30-day supply of meds*).
- □ I am newly establishing / re-establishing care and will work with my case manager to enroll (*30-day supply of meds*).
- □ My case manager has determined that I am not a good candidate for health insurance. *Your case manager must submit written justification.*
- □ I am eligible for insurance through my employer, COBRA, spouse, partner, parent, Medicare, the Marketplace, or Ryan White Part B. Coverage Effective: ____/____/____
- □ Other *Your case manager must submit written justification.*

**9. Medicaid**

*Are you enrolled in Medicaid?*

□ Yes, I am enrolled
- □ I have Pregnant Women's Program; Expected Due Date ____/____/____

□ I applied, but was denied. Denial Reason: _____

□ I am still awaiting a decision about my Medicaid eligibility:
- □ Application pending submission
- □ Application submission date: ____/____/____

□ No, I have not applied because (*select all that apply*):
- □ I am a non-disabled adult
- □ I am undocumented thus ineligible
- □ My income and/or assets exceed Medicaid eligibility requirements
- □ I am eligible for health insurance through my employer (including COBRA) thus ineligible
- □ I am eligible for health insurance through my spouse/partner/parent/other thus ineligible
- □ Other reason(s) I have not applied for Medicaid *Your case manager must submit written justification.*

**10. Employer, Spouse, Parent, Medicare or Marketplace Health Insurance**

*Do you have health insurance through an employer, COBRA, spouse, partner, parent, Medicare or Marketplace?*

□ No—complete section 10b on page 4
□ Yes—complete section 10a below *and* section 10b on page 4 for coverage you do not have
□ Not Applicable, seeking Supportive Services or Case Management Only—skip to section 11 on page 5

**10a. Health Insurance Coverage through an Employer, Spouse, Parent, Medicare or the Marketplace**

I am <u>enrolled</u> in health insurance coverage through: □ Employer □ COBRA □ Spouse □ Partner □ Parent
(*select all that apply*) □ Marketplace □ Medicare □ Other: _____

*If you are not already enrolled but will be eligible to enroll in the future, then you will also need to submit plan details and enrollment and effective date documentation.*

Plan Name: _____
Health Insurance Company Name: _____
Policy Holder Name: _____
Effective Date: ____/____/____ Plan Year: _____ to _____
*Start Month* *End Month*
HIV Provider In-Network? □ Yes □ No
Access to HIV Medications? □ Yes □ No
□ Individual □ Family Maximum Out of Pocket (MOOP): _____
Amount of MOOP Met to Date: _____

**10b. No Health Insurance Coverage through an Employer, Spouse, or Parent**

*No Employer Health Insurance*

- ☐ I am unemployed
- ☐ My employer does offer it, but I am not eligible:
  - ☐ I am undocumented
  - ☐ It is a new job and I am eligible: **Documentation required*
    Enrollment date _____ /_____ /_____
    Effective date _____ /_____ /_____
  - ☐ I missed the open enrollment period **Documentation required*
    Enrollment date _____ /_____ /_____
    Effective date _____ /_____ /_____
  - ☐ I work part-time
  - ☐ I work full-time, but am ineligible **Documentation required*
  - ☐ Other **Documentation required*
- ☐ My employer does not offer it to anyone
- ☐ I am self-employed and do not offer it to anyone
- ☐ My employer does offer it, but:
  - ☐ Coverage is insufficient **Documentation required*
  - ☐ Coverage is unaffordable **Documentation required*
  - ☐ I decline health insurance available to me and choose to be uninsured
  - ☐ My case manager has determined that I am not a good candidate for health insurance **Documentation required*
  - ☐ Other **Documentation required*

*No Health Insurance through Spouse*

- ☐ I am not married
- ☐ My spouse's employer does offer it, but I am not eligible:
  - ☐ I am undocumented
  - ☐ My spouse is undocumented
  - ☐ It is a new job and I am eligible: **Documentation required*
    Enrollment date _____ /_____ /_____
    Effective date _____ /_____ /_____
  - ☐ I missed the open enrollment period **Documentation required*
    Enrollment date _____ /_____ /_____
    Effective date _____ /_____ /_____
  - ☐ Spouse works part-time
  - ☐ Spouse works full-time, but is ineligible **Documentation required*
  - ☐ Other **Documentation required*
- ☐ My spouse is self-employed and does not offer it to anyone
- ☐ My spouse is deceased and I am not re-married
- ☐ My spouse is unemployed
- ☐ My spouse's employer does not offer it to anyone
- ☐ My spouse's employer does offer it, but:
  - ☐ Coverage is insufficient **Documentation required*
  - ☐ Coverage is unaffordable **Documentation required*
  - ☐ I decline health insurance available to me and choose to be uninsured
  - ☐ My case manager has determined that I am not a good candidate for health insurance **Documentation required*
  - ☐ Other **Documentation required*
- ☐ My spouse refuses to offer it to me
- ☐ I am not in contact with my spouse
- ☐ I am separated; I receive no health insurance support from my spouse

*No Health Insurance through Parent*

- ☐ I am age 26 or older
- ☐ My parent(s) is unemployed
- ☐ I am not in contact with either of my parents
- ☐ My parent's employer does offer it, but I am not eligible:
  - ☐ I am undocumented
  - ☐ My parent(s) is undocumented
  - ☐ It is a new job and I am eligible: **Documentation required*
    Enrollment date _____ /_____ /_____
    Effective date _____ /_____ /_____
  - ☐ I missed the open enrollment period **Documentation required*
    Enrollment date _____ /_____ /_____
    Effective date _____ /_____ /_____
  - ☐ Parent(s) works part-time
  - ☐ Parent(s) works full-time, but is ineligible **Documentation required*
  - ☐ Other **Documentation required*
- ☐ My parent(s) is self-employed and does not offer it to anyone
- ☐ My parent's employer does not offer it to anyone
- ☐ My parent(s) is deceased
- ☐ My parent(s) refuses to offer it to me
- ☐ My parent's employer does offer it, but:
  - ☐ Coverage is insufficient **Documentation required*
  - ☐ Coverage is unaffordable **Documentation required*
  - ☐ I decline health insurance available to me and choose to be uninsured
  - ☐ My case manager has determined that I am not a good candidate for health insurance **Documentation required*
  - ☐ I decline being on my parent(s) plan **Documentation required if seeking insurance services*
  - ☐ Other **Documentation required*

**11. Authorization for Release of Information**

☐ Not Applicable

☐ I hereby authorize the Utah Ryan White Part B Program to release information to the following individual(s):
Name (please print):_____ Relation:_____
Name (please print):_____ Relation:_____
Name (please print):_____ Relation:_____

This request and authorization applies to information gathered through Utah Ryan White Part B Program activities.
I understand that my records are protected under Federal regulations and cannot be disclosed without my written consent unless otherwise provided for under the regulations. This document serves as my consent for the release of information to the individual(s) set forth above.
I also understand that I may revoke this consent at any time, in writing, except to the extent that action has been taken in reliance on it.

**12. Certification of Application Accuracy & Completeness**

I certify that all information contained within and submitted with this application is true, correct, and complete to the best of my knowledge. I understand I am required to supply all information needed to determine my enrollment and verify my true circumstances. I realize that providing false information may disqualify me from Utah Ryan White Part B Program services. The Utah Ryan White Part B Program cannot pay for services that have been paid or can reasonably be paid by any State, Federal or private entity that provides health benefits. I understand that all information may be verified by the Utah Ryan White Part B Program. I understand that failure to cooperate or provide correct information may lead to either delays or denial/ termination of services. Cooperation includes completion and execution of all required forms and releases.

18 USC 1001 provides, among other things, that whoever knowingly and willfully makes or uses a document or writing containing any false, fictitious, or fraudulent statement of entry, in any manner within the jurisdiction of any department or agency of the United States, shall be fined not more than $10,000, imprisoned for not more than five years, or both.

I understand it is my responsibility to stay in communication with my case manager / benefits specialist by immediately informing them of changes in my health, income, health insurance, residency, address, phone number, marital status, household size, and/or housing / living arrangements and by responding to my case manager's / benefits specialist's communications (calls, letters, etc.) to the best of my ability.

**13. Disclosure Consent**

I understand that my records are protected under State and Federal regulations and cannot be disclosed without my written consent. I understand that information can be released for billing, chart audits, program monitoring/quality management, data reporting, health insurance, needs assessment purposes and the provision of services. This document serves as my consent for the release of information. I also understand that I may revoke this consent at any time, in writing, except to the extent that action has been taken in reliance on it.

**14. Client Rights and Responsibilities**

I am applying for Utah Ryan White Part B Program services. By signing at the end of this authorization, I state that I have read the Rights and Responsibilities within the *Instructions for Utah Ryan White Part B Program Application* and understand the conditions for my participation. I verify that I have a copy of the Rights and Responsibilities.

*I certify that I have reviewed and understand the Disclosure Consent, Certification of Application Accuracy & Completeness, and Client Rights and Responsibilities. I understand that if I have questions or concerns, it is my responsibility to communicate with my Case Management Agency.*

**Applicant Name:** _____

**Applicant Signature:** _____ **Date:** _____

**Application Checklist—Must have all information and items enclosed for a complete application**

- HIV Status—*completed by Medical Provider*
- Proof of Utah Residency
  - Acceptable documentation for residency verification attached to the application
  - Residency Verification Form *(If applicable)*
- Proof of Income from all sources for client and legal spouse
  - Acceptable documentation for income verification attached to the application *(If applicable)*
  - Verification of Employment Form *(If applicable)*
- Proof of Insurance Availability through an Employer, Spouse, Parent, Medicare or the Marketplace
  - Verification of Employment and Health Insurance Availability Form (*If applicable)*
- Client Rights and Responsibilities
  - Client provided a copy of the Rights and Responsibilities