

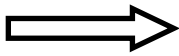
## Instructions for Utah Ryan White Part B Program Self-Attestation

(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:	CM	SS	ADAP-M	ADAP-I					
				Group Plan	Medicare	COBRA	Market-place	DPI	
HIV+ Utah Resident Low Income									
Eligibility									
Federal Poverty Level (FPL)	500% FPL	250% 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	v
Medical Case Management	v	v	v	v	v	v	v	v	v
Oral Health		v	v	v	v	v	v	v	v
Emergency Financial Assistance		v	v	v	v	v	v	v	v
Food Vouchers		v	v	v	v	v	v	v	v
Transportation		v	v	v	v	v	v	v	v
Prescriptions			v	v	v	v	v	v	v
Outpatient Ambulatory Medical Care			v	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Medical Cost Sharing Assistance				v	v	v	v	v	v
Insurance Premiums					v	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
<input type="checkbox"/> Utah Drivers License	<i>Cannot be expired more than two calendar months</i>
<input type="checkbox"/> Utah State ID	<i>Cannot be expired more than two calendar months</i>
<input type="checkbox"/> Tribal ID	<i>Cannot be expired more than two calendar months</i>
<input type="checkbox"/> Paystub or Earning Statement	<i>Dated within last two calendar months</i>
<input type="checkbox"/> Documents issued by a financial institution	<i>Bank statement, credit card statement, etc. dated within last two calendar months</i>
<input type="checkbox"/> Current rental or lease agreement	<i>Signature pages and length of agreement must be included</i>
<input type="checkbox"/> Recent utility bill	<i>Dated within last two calendar months Cell phone bills are not accepted</i>
<input type="checkbox"/> Current mortgage statement	<i>Dated within last two calendar months</i>
<input type="checkbox"/> Most recent property tax document	<i>Dated within last 12 months</i>
<input type="checkbox"/> Copy of Social Security Award Letter	<i>Current year benefit letter</i>
<input type="checkbox"/> Document issued by the State of Utah	<i>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</i>
<input type="checkbox"/> Document issued by the United States Federal Government	<i>Public assistance documents, tax documents, tax transcripts, etc. dated within current calendar year or within last two calendar months depending on document</i>
<input type="checkbox"/> Military/ Veterans Affairs ID	<i>Cannot be expired more than two calendar months</i>
<input type="checkbox"/> Approved letter from case management agency, homeless shelter, or transitional service provider	<i>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</i>

**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.)	<p><i>One of the following:</i></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <i>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).</i></li> <li><input type="checkbox"/> <i>Most recent tax statements or W-2 Forms may be accepted if client is still employed with same company.</i></li> <li><input type="checkbox"/> <b>Verification of Employment Form</b> 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.</li> </ul>
Wages and salaries from informal employment with no paystubs	<ul style="list-style-type: none"> <li><input type="checkbox"/> <i>Depends on source. Work with case management agency to determine most appropriate documentation. The <b>Verification of Employment Form</b> or other Employer Statement may be appropriate.</i></li> </ul>
Self– Employment	<ul style="list-style-type: none"> <li><input type="checkbox"/> <i>IRS Form 1040 <b>and</b> Schedule C or Schedule E for most recent tax filing period</i></li> </ul>
Social Security Income	<ul style="list-style-type: none"> <li><input type="checkbox"/> <i>Current year benefit letter</i></li> </ul>
Benefits (Life Insurance, Disability, Educational Assistance, Survivor’s, etc.)	<ul style="list-style-type: none"> <li><input type="checkbox"/> <i>Current year benefit letter</i></li> </ul>
Capital Gains, Stocks, Bonds, Cash, Dividends, Trust, Investment Income	<ul style="list-style-type: none"> <li><input type="checkbox"/> <i>Tax Documentation for most recent period or documentation from financial institution</i></li> </ul>
Public Assistance/Unemployment	<ul style="list-style-type: none"> <li><input type="checkbox"/> <i>Unemployment Statement, award letter or paystubs, or General Assistance Letter from DWS for current period</i></li> </ul>
Retirement (Pensions, Annuities, 401k, etc.)	<ul style="list-style-type: none"> <li><input type="checkbox"/> <i>Current benefit statement</i></li> </ul>
Alimony	<ul style="list-style-type: none"> <li><input type="checkbox"/> <i>Current benefit letter or other official documentation</i></li> </ul>
Rental Income	<ul style="list-style-type: none"> <li><input type="checkbox"/> <i>Current rental agreement, tax documentation, or other official documentation</i></li> </ul>
Veterans Benefits	<ul style="list-style-type: none"> <li><input type="checkbox"/> <i>Current year benefit letter</i></li> </ul>
“Other” Income	<ul style="list-style-type: none"> <li><input type="checkbox"/> <i>Depends on source. Work with case management agency to determine most appropriate documentation.</i></li> </ul>
Legal Spouse’s Income	<ul style="list-style-type: none"> <li><input type="checkbox"/> <i>See above for acceptable documentation by income type</i></li> </ul>

**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:

<input type="checkbox"/> Assessment of available coverage to the client	<input type="checkbox"/> Assistance in enrolling in health coverage
<input type="checkbox"/> Education of the benefits of health insurance	<input type="checkbox"/> 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.***

<b>Clinic 1A University of Utah</b>	<b>Utah AIDS Foundation</b>	<b>Utah Department of Health</b>
Mail: 30 North 1900 East RM: 4B319 Salt Lake City, UT 84132 ATTN: Amanda Sanchez	Mail: 1408 South 1100 East Salt Lake City, UT 84105	Mail: Box 142104 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 Self-Attestation Form (April 2019)**

**Office Use Only:** CM Agency:  C1A  UAF  UDOH Assisted with Application: \_\_\_\_\_  
 Check applicable service(s): \_\_\_\_\_ Contact for Follow-Up: \_\_\_\_\_  
 DPI  MP  Employer  COBRA  Medicare Co-Pay  Medicare Premium & Co-Pay  ADAP-M  SS  CM Only  
 Request to Expedite by: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**1. Applicant Information** C1A MRN: \_\_\_\_\_  UAF Not Applicable  
 Legal Name (Last, First, Middle): \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Preferred Name: \_\_\_\_\_  
 Current Gender:  Male  Female  Transgender (Male to Female)  Transgender (Female to Male)  Refused

**2. Applicant Contact Information**  Do not contact me by mail The Program has my permission to text and/or e-mail me:  Yes  No  
 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: \_\_\_\_\_

**3. HIV Status** Are you currently taking HIV medications?  Yes  No

**4. Health Insurance**  No health insurance / uninsured:  
*Select all of the health insurance types you have:*  
 Private-Individual (DPI / COBRA / MP)  I decline health insurance available to me.  
 Private-Employer or other Group Plan  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.  
 Medicare Part A/B  It is currently open enrollment and I need medications while pursuing health insurance (30-day supply of meds).  
 Medicare Part D or other Medicare pharmacy coverage  I am newly establishing / re-establishing care and will work with my case manager to enroll (30-day supply of meds).  
 Medicaid, Children’s Health Insurance Program (CHIP), or other public plan  My case manager has determined that I am not a good candidate for health insurance. *Your case manager must submit written justification.*  
 Veterans Health Administration (VA), Tricare or other military health care  I am eligible for insurance through my employer, COBRA, spouse, partner, parent, Medicare, the Marketplace, or Ryan White Part B. Coverage Effective: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Indian Health Services (IHS)  Other *Your case manager must submit written justification.*  
 Other Plan: \_\_\_\_\_

**5. 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.*

**6. 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 6b on page 2  
 Yes—complete section 6a on page 2 and section 6b on page 2 for coverage you do not have  
 Not Applicable, seeking Supportive Services or Case Management Only—skip to section 7 on page 3

**6a. Health Insurance Coverage through an Employer, Spouse, Parent, Medicare or the Marketplace**

I am enrolled 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 \_\_\_\_\_

HIV Provider In-Network?  Yes  No Start Month End Month

Access to HIV Medications?  Yes  No

Individual  Family Maximum Out of Pocket (MOOP): \_\_\_\_\_

Amount of MOOP Met to Date: \_\_\_\_\_

**6b. 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*

**7. Change(s)**

**NO CHANGE**

I certify that my health insurance, Utah residency / address, housing / living arrangements, marital status, household size, and household income have not changed.

*If no changes, then proceed to section 12 on page 5.*

**CHANGE** Complete corresponding form sections and submit documentation where applicable

- |                                      |                             |  |
|--------------------------------------|-----------------------------|--|
| Health insurance change:             | <input type="checkbox"/> No | <input type="checkbox"/> Yes—change reported in sections 4, 5 and 6              |
| Utah residency / address change:     | <input type="checkbox"/> No | <input type="checkbox"/> Yes—change reported in section 2 and complete section 8 |
| Housing / living arrangement change: | <input type="checkbox"/> No | <input type="checkbox"/> Yes—complete section 9                                  |
| Marital status change:               | <input type="checkbox"/> No | <input type="checkbox"/> Yes—complete section 10                                 |
| Household size change:               | <input type="checkbox"/> No | <input type="checkbox"/> Yes—complete section 10                                 |
| Household income change:             | <input type="checkbox"/> No | <input type="checkbox"/> Yes—complete section 11                                 |

**8. Utah Residency / Address Change**

*Submit at least one 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

**9. Housing Change**     Stable Permanent Housing     Temporary Housing     Unstable Housing

**10. Household Size or Marital Status Change**

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

**11. Household Income Change**

**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 self-attestation form to serve as income verification. **Refer to "Instructions for Utah Ryan White Part B Program Self-Attestation" 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 <input type="checkbox"/> Not Married <input type="checkbox"/> I'm separated; I receive no financial support from my spouse	Gross Monthly Income
Wages and salaries from formal employment (Wages, Tips, Commission, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
Wages and salaries from informal employment with no paystubs	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
Self-Employment	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
Social Security Income	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
Benefits (Life insurance, Disability, Educational Assistance, Survivor's, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
Capital Gains, Stocks, Bonds, Cash, Dividends, Trust, Investment Income	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
Public Assistance / Unemployment	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
Retirement (Pensions, Annuities, 401k, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
Alimony	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
Rental Income	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
Veterans Benefits	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
"Other" Income	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
<b>Do you work 30 or more hours per week?</b>	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>		<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	



**12. 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.

**13. 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.

**14. 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.

**15. 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 Self-Attestation* 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—Are you currently taking HIV medications?
- Proof of Utah Residency
  - Acceptable documentation for residency verification attached to the application (*If change reported*)
  - 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 / If change reported*)
  - 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