

ARIZONA RYAN WHITE AND ADAP - HALF BIRTHDAY RENEWAL APPLICATION

If any of the information below has changed since your last application, please submit proof of the new information.

CLIENT INFORMATION				
Last Name	First Name	Date of Birth ____/____/____		
ADDRESS & PHONE				
Home Address	City	State	ZIP Code	Mail OK? <input type="checkbox"/> Yes <input type="checkbox"/> No
Mailing Address (if different)	City	State	ZIP Code	Mail OK? <input type="checkbox"/> Yes <input type="checkbox"/> No
Home Phone	May we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No	Other Phone	May we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No	
HOUSEHOLD SIZE & INCOME				
Household Size	Monthly Income	Annual Income		
EMPLOYMENT STATUS				
Check all that apply:				
<input type="checkbox"/> Full-time ____ hours/week	<input type="checkbox"/> Social Security Disability Insurance (SSDI)	<input type="checkbox"/> Unemployed		
<input type="checkbox"/> Part-time ____ hours/week	<input type="checkbox"/> Social Security Income (SSI)	<input type="checkbox"/> Full or part-time college student		
<input type="checkbox"/> Seasonal/ temporary	<input type="checkbox"/> Other(describe): _____	<input type="checkbox"/> Retired		
<input type="checkbox"/> Self-employed				
HEALTH COVERAGE PAYER & MEDICAL PROVIDER				
Do you have health insurance? Check all that apply.				
<input type="checkbox"/> AHCCCS	<input type="checkbox"/> Private – Employer: _____	<input type="checkbox"/> Veterans Affairs		
<input type="checkbox"/> ALTCS	<input type="checkbox"/> Private – Individual: _____	<input type="checkbox"/> Indian Health Service		
<input type="checkbox"/> Medicare	<input type="checkbox"/> FFM Plan: _____	<input type="checkbox"/> No Insurance		
<input type="checkbox"/> A <input type="checkbox"/> B				
<input type="checkbox"/> Advantage Plan	<input type="checkbox"/> Other: _____	Medical Provider: _____		
<input type="checkbox"/> D <input type="checkbox"/> Full LIS				
SIGNATURE				
The information provided in this application is true and accurate to the best of my knowledge. Any unreported items may result in loss of eligibility. I will report any changes to my household income, household size, address, health insurance and/or anything else that may affect my eligibility for services. If I do not, I may not be eligible or may have to re-pay the Ryan White Program.				
Date: _____ Applicant Signature: _____				
FOR OFFICE USE ONLY:				
Applicant is applying for: <input type="checkbox"/> Ryan White Part A <input type="checkbox"/> Ryan White Part B <input type="checkbox"/> Ryan White Part C <input type="checkbox"/> ADAP <input type="checkbox"/> Dental				
Application Type: <input type="checkbox"/> Half-Bday Renewal <input type="checkbox"/> Half-Bday Re-Enroll				
<input type="checkbox"/> Application logged in Reviewer: _____				
FOR INCOMPLETE APPLICATIONS Missing Documents: \$\$ Res Labs Other: _____ Reminder Contact Date: _____ Type: E-Mail VM TC FF Letter to be sent: _____ Sent: _____ To Be Closed on: _____ Missing Documents received on Date ____/____/____				
_____ Date Received	_____ Date Complete	_____ Date Sent to ADAP	_____ Date Entered in CW	_____ Date Attached in CW