

Arizona Ryan White and ADAP Application

APPLICANT INFORMATION

Last		First			MI	
Birth date (month/day/year)				AKA (also known by these other names including Maiden)		
Self-Identified Gender <input type="checkbox"/> Male <input type="checkbox"/> Transgender – Male to Female <input type="checkbox"/> Female <input type="checkbox"/> Transgender – Female to Male				Gender at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female		
Ethnicity <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Hispanic Subgroup if applicable: _____				Race (choose all that apply) <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> American Indian/Alaska Native Subgroup if applicable: _____		
Language Preference <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____				Social Security Number (SSN)*		
Refugee? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, share Month & Year of Settlement: ___/___/___				What was your Country of Birth: _____		
Asylum Seeker? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, share Month & Year of Settlement: ___/___/___				What was your Country of Origin: _____		
Primary Phone # _____ Type: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Other OK to leave messages? <input type="checkbox"/> Yes <input type="checkbox"/> No				Secondary Phone # _____ Type: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Other OK to leave messages? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Alternative Contact Person & Relationship				Phone Number		Aware of Status? <input type="checkbox"/> Yes <input type="checkbox"/> No
Ryan White Case Manager Name		Agency		Phone Number		Contact In Lieu of Client <input type="checkbox"/> Yes <input type="checkbox"/> No
Medical Provider Name		Facility Name		Phone Number		Fax Number
Email Address						OK to E-Mail? <input type="checkbox"/> Yes <input type="checkbox"/> No
Home Address <input type="checkbox"/> I Am Homeless		Apt/Suite #	City	State	Zip Code	OK to Mail? <input type="checkbox"/> Yes <input type="checkbox"/> No
Mailing Address(if different)		Apt/Suite #	City	State	Zip Code	OK to Mail? <input type="checkbox"/> Yes <input type="checkbox"/> No

* SSN information is not used for eligibility determination. It is used to verify income, AHCCCS eligibility, and/or verify Medicare coverage.

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"/> Initial/New <input type="checkbox"/> Bday Renewal <input type="checkbox"/> Half-Bday Renewal <input type="checkbox"/> Bday Re-Enroll <input type="checkbox"/> Half-Bday Re-Enroll						
<input type="checkbox"/> Application logged in Reviewer: _____						
FOR INCOMPLETE APPLICATIONS						
Missing Documents: DX \$\$ 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		

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RESIDENCY

Please provide **ONE** of the following residency documents issued within the allowable timeframes.

- The documents must be dated and include the client's name and home address (no P.O. Boxes).
- **Attach copies to this application.**

RESIDENCY DOCUMENTS (check ONE and attach a copy of document)
<input type="checkbox"/> Annual income award letter from a government agency or pension – <i>issued for the current year</i>
<input type="checkbox"/> Mortgage, lease/rental agreement or non-permanent housing letter – <i>most recent, not expired</i>
<input type="checkbox"/> Any Document or mail with the client's name and address – <i>issued within the last 60 days</i> Examples include: AHCCCS, DES, Medicare, utility bill, bank statement, other bills, check stubs
<input type="checkbox"/> Driver's License or AZ ID Card – <i>issued within the last year</i>
<input type="checkbox"/> Tribal enrollment – <i>most recent, not expired</i>
<input type="checkbox"/> US Immigration Identification Card – <i>most recent, not expired</i>
<input type="checkbox"/> Attestation of residency or homelessness from a social service provider, medical provider, or family/friend – signed within 30 days (use one of the attestations below or provide a signed and dated written statement with the client's name, date of birth, and address)

Case Manager Attestation of Home Visit	
Agency Use Only: May Only be completed by Case Manager or Part A Eligibility Specialist	
I affirm that I have visited _____	
at _____.	
_____ Staff Member Printed Name	_____ Name of Provider Agency
_____ Staff Member Signature	_____ Date
Attestation of Homelessness	
Agency Use Only: May only be completed by a social service or medical provider	
I affirm the client is homeless.	
_____ Staff Member Printed Name	_____ Name of Provider Agency
_____ Staff Member Signature	_____ Date
Other Attestation of Residency	
May be completed by Medical Provider, Family or Friend	
I affirm to the best of my knowledge : _____	
lives at : _____	
_____ Printed Name	_____ Relationship to client
_____ Signature	_____ Date

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INCOME AND HOUSEHOLD SIZE

Please provide income documents issued within the allowable timeframes. Attach copies to this application.

INCOME SOURCE DOCUMENTS (check all that apply and attach copies)
<input type="checkbox"/> Annual award letter (<i>Social Security, VA, annual pension, etc.</i>)
<input type="checkbox"/> Other award letter (<i>TANF, Unemployment, etc.</i>)
<input type="checkbox"/> 1 month of check stubs or employer statement if no check stub is received
<input type="checkbox"/> Self-employment records (<i>1099, current Profit and Loss form or most recent bank statements</i>)
<input type="checkbox"/> Other income source not listed above (requires Certification of Income and/or Support)
<input type="checkbox"/> No income (requires Certification of Income and/or Support)

In the table below, list every family member residing within your household and/or can be claimed as an exemption on your federal tax return (i.e. legal spouse, biological/adopted children, individual you provide more than 50% support for)

HOUSEHOLD INFORMATION TABLE						
Applicant or Family Member Name	Relationship	Gross Income if over 18 years old	Frequency	Source	Over 18 Years Old?	Can be Claimed on Taxes?
Self	Applicant				<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

EMPLOYMENT STATUS FOR APPLICANT/ADULT IN THE FAMILY UNIT		
<input type="checkbox"/> Full-Time ___ hours per week	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Self-employed
<input type="checkbox"/> Part-Time ___ hours per week	<input type="checkbox"/> Social Security Disability Insurance (SSDI)	<input type="checkbox"/> Other (describe): _____
<input type="checkbox"/> Seasonal/ Temporary	<input type="checkbox"/> Social Security Income (SSI)	_____
<input type="checkbox"/> Full or part-time college student	<input type="checkbox"/> Retired	_____

CERTIFICATE OF INCOME
<p>I confirm that I am supporting myself in the following manner (check and complete all that apply):</p> <p><input type="checkbox"/> I or an adult in my household receives money for work performed for which no paycheck is received, with the average monthly earnings of \$_____. The occupation for which these monies are earned is _____.</p> <p><input type="checkbox"/> I am homeless or living in a shelter</p> <p><input type="checkbox"/> I am receiving assistance for obtaining food, water, housing &/or clothing from: _____ <i>Please attach letter of support from this person or have this person complete the 'Certificate of Support' below.</i></p> <p>I attest that, to the best of my knowledge and belief that the information submitted is accurate and complete</p> <p style="text-align: center;"> </p> <p>Applicant Signature Date</p>

CERTIFICATE OF SUPPORT
<p>I, _____, am providing support to _____ for him/her to obtain food, water, housing, and clothing.</p> <p style="text-align: center;"> </p> <p>Signature Date</p>

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MEDICAL PROVIDER PAGE

MEDICAL PROVIDER SIGNATURE – ALL APPLICANTS

I certify that to the best of my knowledge and belief all information I have provided below is accurate and complete.

Signature of Medical Provider

Date

PROVIDER INFORMATION – ALL APPLICANTS

Applicant Name		Applicant Birth Date		
Medical Provider Name		License Number		
Medical Provider Address	Apt/Suite #	City	State	Zip Code
Medical Provider Phone: ()		Medical Provider Fax: ()		

LAB DATA – ALL APPLICANTS

Test Name	Result	Date of Test
FUTURE LAB DRAW DATE		
CD4 CELL COUNT (medical provider can follow DHHS guidelines)		
VIRAL LOAD (within the last 6 months)		

HEPATITIS C SCREENING – ALL APPLICANTS

Does Applicant have Hepatitis C?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Would Applicant like additional information about Hepatitis treatments through ADAP?	<input type="checkbox"/> Yes <input type="checkbox"/> No

MEDICATION(S) PRESCRIBED – ADAP ONLY

PLEASE list full prescription below with a copy of prescriptions OR attach a copy of the eRX

Drug	Strength	Quantity	Instructions	# Refills

I certify that this applicant has been diagnosed as having HIV infection.

I understand that I am required to notify the vendor pharmacy within 7 calendar days of the following:

- Prescribing a new medication
- Discontinuing a medication

I agree to notify the Arizona ADAP/Ryan White programs within 14 calendar days following my notification of:

- Death of the patient/client
- Change in the HIV Medical Provider

If the client is going to go without Antiretroviral (ARV) Therapy for longer than 90 days, you will need to complete the 90 Day Medical Provider Override Form -Addendum 3; for questions please contact ADAP at 602-364-3610 OR 800-334-1540.

Please return to: ADAP, Arizona Dept. of Health Services
150 N. 18th Avenue, Suite 130, Phoenix, AZ 85007-3233
Fax: (602) 364-3263
Phone: Toll-Free (800) 334-1540

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RYAN WHITE PART A ONLY

Please review each statement and sign below:

- I may qualify for Ryan White funded services even if I have other insurance.
- I will report any changes to my household income, my address, and other things that may affect my services. If I do not, I may not be eligible or may have to re-pay the Ryan White Program
- At least every six months, I will complete the required eligibility process. If I fail to provide documents, I will not remain in the program.
- 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.

RYAN WHITE PART A RELEASE OF INFORMATION

I, _____ (Client Name), authorize Care Directions, Arizona School of Dentistry and Oral Health, Chicanos Por La Causa, Maricopa County Employee Benefits and Health, Ebony House, Maricopa Integrated Health System, Maricopa County Office of Health Education & Promotion, Phoenix Indian Medical Center, Southwest Center for HIV/AIDS and Sun Life, Ryan White HIV/AIDS Program Grantees and/or Contractors, to disclose my protected health information (PHI) and other information from my records to any Ryan White HIV/AIDS Program (Ryan White) Grantee or Contractor operating in Maricopa County and/or Pinal County, Arizona.

The purpose of the disclosure is to permit Ryan White HIV/AIDS Program Grantees and/or Contractors to exchange my PHI or other information from my records to Ryan White Contractors and Grantees for the purposes of:

- Continuity of care, treatment, payment, and health care operations, including eligibility, demographic, emergency treatment, payments to Contractors or other statistical reporting information;
- Mandated reporting, including client-level data reporting;
- Disclosures required by law;
- Legal process and proceedings;
- Oversight including quality assurance reviews and audits of Ryan White-funded services provided;
- Disclosure to a Medical Examiner;
- Disclosure of notifiable public health conditions; and
- Inclusion in shared data systems for demographic, eligibility, and other statistical reporting;
- If in the course of providing services to a client, a RWPA provider identifies information that could be harmful to the client or the public; the provider may report that information to the appropriate authorities.

If required for the purposes listed above, I authorize the disclosure of the following information for the period of time from the date of my signature to one (1) year from the date of my signature:

- HIV/AIDS and other communicable disease information, including HIV Counseling and Testing;
- Behavioral, Mental Health or Psychiatric treatment information; and/or
- Substance abuse treatment information.

Unless I revoke this authorization earlier, it will expire one (1) year from the date of my signature. I also understand that my revocation will not apply to information that has already been released in response to this Release. To revoke this authorization, I must submit a written request to:

Central Eligibility Office, Care Directions
1366 E. Thomas Road, Suite 203
Phoenix, AZ 85014

By signing this Release of Information, I release all Ryan White Grantees and Contractors, their employees, officers, directors, medical staff, and agents from any legal responsibility or liability for the disclosure of information to the extent indicated and authorized in this Release. I also understand that Ryan White Grantees and Contractors will maintain the confidentiality of my disclosed PHI or other information, and that they will use my PHI or other information only for the purposes listed above. I understand the matters discussed on this Release of Information and that by signing below, I acknowledge that I have received a copy of the Ryan White Program Notice of Privacy Practices, Central Eligibility Provider List, Client Rights/Responsibilities, and Client Grievance Policy

Printed Name

Signature

Date

Signature of Legal Representative

Relationship to Client

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ADAP/RYAN WHITE PART B ONLY

ADAP/RWPB RELEASE OF INFORMATION

Arizona Department of Health Services – AIDS Drug Assistance Program (ADAP) Application (Under Provision of A.A.C. R9-6-401, et seq)

I agree that I or my designated representative must provide AZ ADAP with proof of ineligibility for enrollment for Arizona Health Care Cost Containment System (AHCCCS) and/or for Medicare Part D low-income subsidy, if not provided with this application. I also agree that I or my designated representative must provide AZ ADAP with proof of enrollment in a Medicare drug plan, if I am eligible for Medicare. Last, I agree that I or my designated representative must provide AZ ADAP with proof of or exception from enrollment the Federally Facilitated Marketplace, if applicable.

I grant permission to AZ ADAP to share the minimum necessary information contained in this application with AHCCCS, for the purpose of determining AHCCCS eligibility, with Medicare and the Social Security Administration for the purpose of determining eligibility for a low-income subsidy and enrollment in a Medicare drug plan, with my primary care provider or their designee to confirm clinical information and acquire test results related to the service I am requesting, with the vendor pharmacy to assist with drug distribution, with other Ryan White providers in Arizona with whom I am enrolled to maintain my enrollment in ADAP or ADAP-Assist, and with any other entity as necessary to establish eligibility for enrollment in AZ ADAP, to maintain continuity of care, treatment, payment and health care operations.

I or my designated representative agrees to notify the AZ ADAP of any changes that affect my eligibility within 30 calendar days. Such changes include: any change in MAGI-based income, household size, residential or mailing address, phone number, employment status, availability of insurance coverage, AHCCCS eligibility, or primary care provider.

I understand that my AZ ADAP eligibility will terminate if I do not refill my AZ ADAP-covered Anti-Retroviral (ARV) medications for greater than 90 days.

I certify that to the best of my knowledge and belief, I am eligible for AZ ADAP and all statements made herein regarding personal and other non-medical information are accurate and complete. I certify that I am not eligible for any health insurance plan that would provide the support for which I am applying, other than those which I have declared.

I understand that my failure to be accurate and complete may prevent or delay a determination of eligibility to receive assistance from AZ ADAP, or may result in termination of my enrollment.

I understand that copies of the rules and policies for support documents are available upon request through the AZ ADAP Office.

I understand that if there is any discrepancy in the documents provided to AZ ADAP, I must present government issued documentation to confirm my identity.

I understand that AZ ADAP may terminate my enrollment in AZ ADAP if I exhibit violent or threatening behavior to a representative of the AZ ADAP or the AZ ADAP pharmacy.

I understand that AZ ADAP ceases to provide drugs when available funding is exhausted or terminated. AZ ADAP is not an entitlement program and does not create a right to assistance absent available funding (R9-6-402).

I, _____ (applicant's printed name) authorize staff members of the Ryan White Part B and/or ADAP of the Arizona Department of Health Services, to represent me for the following purposes:

1. During my ADAP enrollment, facilitating the payment of premiums for marketplace coverage by the ADAP, provided that the ADAP determines that the marketplace coverage remains the most cost effective means to provide me with HIV medications for which I am seeking assistance from the ADAP. Please note that the Advance Premium Tax Credit (APTC) must be applied to total premium cost prior to ADAP facilitating the payment of premiums for marketplace coverage.
2. I further authorize the staff members named above, in their capacity as staff members of the ADAP of the Arizona Department of Health Services, to disclose my confidential information to the extent necessary to carry out the three purposes listed above.

I understand and agree that this authorization will remain in effect for a period of one year from the date of signature.

Applicant Name (PRINT)

Signature

Date

Please return to: ADAP, Arizona Dept. of Health Services
150 N. 18th Avenue, Suite 130, Phoenix, AZ 85007-3233
Fax: (602) 364-3263
Phone: Toll-Free (800) 334-1540

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SUPPORT DOCUMENT GUIDE

REQUIRED SUPPORT DOCUMENTS – ALL APPLICANTS

Proof of Residency – see page 2 for accepted documents

Proof of Income – see page 3 for accepted documents

Letter of Support – *if applicable*

If you signed the Certificate of Income and/or Support, the person helping you must provide a letter of support

Proof of Healthcare Coverage (as applicable)

AHCCCS card or approval letter

Medicare card

Private health insurance card

AHCCCS Determination (Approval or Denial) – dated within 12 months

- Denial due to failure to submit documentation is not acceptable.
- Enrollment in Federal Emergency Services (FES) is considered an AHCCCS denial.
- Enrollment in the FFM is considered an AHCCCS denial.

Lab Report (Copy of Viral Load lab report done in the last 6 months or Medical Provider Page (MPP))

REQUIRED SUPPORTING DOCUMENTS – ADAP/RWPB

Medicare Extra Help/LIS Award or Denial Letter dated within 24 months

If you are enrolled in the FFM and receive premium assistance from ADAP attach a copy of your federal taxes from the prior year

Medical Provider Page completed and signed by your medical provider (ADAP 340b clients only)

REQUIRED SUPPORTING DOCUMENTS – New Applicants Only

New applicant addendum

Proof of Diagnosis (RWPA clients only)

Medical Provider Page completed and signed by your medical provider (ADAP clients only)

ADDITIONAL SUPPORTING DOCUMENTS –Required under certain circumstances

Benefit/Employment Verification Form

90 Day Medical Provider Override Form

SAAF Authorization for Use and Sharing of Information

Ryan White Self-Employment Worksheet

Income Template