RYAN WHITE SERVICES ELIGIBILITY APPLICATION
KADAP (Kentucky AIDS Drug Assistance Program)
KHICP (Kentucky Health Insurance Continuation Program)
KHHCP (Kentucky Home Health Care Program)
KHCCP (Kentucky HIV/AIDS Care Coordination Program)

***Anyone wishing to receive ADAP, Insurance Continuation, or Core Medical/Support Services funded through Ryan White Part B must complete this application, and be determined to be eligible by the Kentucky Department for Public Health HIV/AIDS Branch, prior to receiving the services. The only exception being, Case Management/Care Coordination for the purpose of, completing the application for eligibility certification or recertification for services.**

Application Check List

Before submitting your application, **BE SURE YOU INCLUDED**:

- **Proof of Residency**
  (You MUST submit one of the following: current copy of signed lease, most recent utility bill, or valid driver's license or official state ID that includes current address; other official mail; statement from a person providing room and board). Proof of current physical address must match the address listed on the application. P.O. Boxes will not be accepted. An individual who is documented as "homeless" by the Case Manager, can complete a self-attestation of residency status.

- **Proof of Income**
  (You MUST submit one of the following: most recent W-2 or 1099, or 2 recent paycheck stubs, or Social Security statement, or food stamp award letter, or unemployment check/letter, or workman's compensation letter, or if self-employed complete tax return). Please provide proof of income for all amounts listed. All documents provided, excluding W-2 or 1099 or tax return, must be LESS than 6 months old. (If you have no income, you MUST include a signed statement that you have no income and explain how you are meeting your needs of daily living).

- **Proof of Insurance or Medicare Part D Plan (If applicable)**
  If you have insurance available, you MUST submit a copy, FRONT AND BACK, of your insurance card to be eligible for the Insurance Continuation Program (KHICP). If un-insured, you must vigorously pursue insurance benefits or document with your initial application, your refusal to participate in an insurance benefits program.

- P**roof of Positive HIV Status**

  Provide a complete name-linked verification of HIV positive status. The following items may be used to verify HIV status: two (2) reactive rapid HIV tests conducted on the same day or a positive confidential Western Blot test result; signed and dated written statement from a medical care provider utilizing the Clinical Information form (CIF); a Testing Counselor, who has been certified by the Centers for Disease Control and Prevention (CDC) training "Fundamentals of HIV Prevention Counseling," may sign and verify HIV status utilizing the CIF; or a discharge summary or other hospital record that verifies HIV positive status.

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Please make sure ALL blanks on the application form are complete and all required proof is submitted. Failure to complete the entire application may cause your approval to be delayed.

The following forms are required for the Initial Application and for the Annual Recertification:

- **Informed Participation Agreement (IPA) Form**
- **Grievance Procedures Form**
- **HIPAA Release of Information Form**
- **Completed Application**
- **Proof of Eligibility Requirements**

The following form can be used for a six-month recertification or if a change needs to be reported:

- **Statement of No Change/Report of Change**

  Please include a completed Clinic Information Form (CIF) with this form, if used for the six month recertification. For Report of Change, include supporting documentation.

Initial Application & Re-certification Form

I understand that I can enroll through any Ryan White HIV/AIDS Program (RWHAP) funded agency in the state or by requesting an application and mailing or faxing it to: **Dept. for Public Health, 275 East Main Street, HS2E-C, Frankfort, KY 40621-0001. Secured FAX (877)353-9380.**

1. Applicant Information:

Applicant name: _____

Home address (Street address or P O Box): _____

City: _____ State: _____ Zip: _____

Requested mailing address (if different than above): **Drugs** ☐ **Correspondence** ☐

_____

Social Security #: _____ Date of birth: _____

Home phone: ( ) _____ County of residence: _____

Cell phone: ( ) _____ Gender: _____ Race: _____

NOTE: We may have to call your home with questions. Please let us know how we should leave messages regarding your HIV services if you are not available.

_____

2. Medical Provider/Social Services:

HIV Medical Provider Name: _____

Case Manager/Care Coordinator Name: _____

3. Medical Coverage (please check all applicable):

____ I have Medicaid

____ I have temporary Medicaid Expiration date _____
(Please provide a copy of your card)

____ I have Medicare

____ I have a Medicare Part D Plan/Other Prescription Coverage Plan

____ I have Private Insurance

Please complete the information below and send a copy (front and back) of your insurance card with this application.

Brand Copay: _____ Generic Copay: _____ or Percentage Pay: _____%
Date coverage started/starts: _____

4. Household/Income Information:

Total Household size: _____
Check all that apply:
☐ Client ☐ Family (Ages) Spouse___ Children___ Other____ ☐ Non-Family

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Check here if you have NO income ☐

If so, please skip to Section 5 and complete a Statement of No Income.

Monthly Gross Income:

Source	**Client**	**Family**	**Non-Family**
Job (check one) Employed ___ Self Employed___	$_____	$_____	$_____
Social Security	$_____	$_____	$_____
Unemployment benefits	$_____	$_____	$_____
Social Security Disability (SSDI)	$_____	$_____	$_____
Supplemental Security Income (SSI)	$_____	$_____	$_____
Survivorship Benefits	$_____	$_____	$_____
Child Support	$_____	$_____	$_____
Retirement/Pension/private Disability	$_____	$_____	$_____
Veterans Administration (VA) benefits	$_____	$_____	$_____
Worker's Compensation	$_____	$_____	$_____
TOTAL:	**$**_____	**$**_____	**$**_____

Do not include inheritance as income.

5. Disclosure Statement:

The information provided in this application will be used to determine eligibility, provide services, ensure compliance with federal guidelines, and apply for future funding for KADAP, KHICP, KHHCP and other core and support services

Some information will be disclosed to the Kentucky HIV/AIDS Surveillance Section as required under 902.KAR 2.020 for statistical purposes; to the University of Kentucky, Kentucky Clinic Pharmacy for the dispensing of client drugs and invoicing; and to your physician and/or Case Manager/Care Coordinator for eligibility determination and service provision/coordination purposes. This application, when filled in, contains patient information that must be protected in accordance with the Health Insurance Portability & Accountability Act. Some information in this application will be supplied to the Medicare/Medicaid office to determine if the client meets the “Medically Frail” criteria. Medically Frail classification will exempt the client from any obligations that may be required to maintain coverage and to determine if they are eligible for any other benefits. x_____ Initial & Date

6. Certification of Information:

I, _____, certify that the information contained in this application is complete and correct. I understand that **I must report ANY changes in household size, income, health insurance, and Medicaid status**. I do hereby authorize the release of any necessary information in this application to the entities listed in the *disclosure statement,* above. All information will be treated with the strictest confidentiality.

I understand that I must update my case record semi-annually by contacting my case manager or by submitting the required documentation to the address or Secured FAX number below.

_____ _____
Applicant's signature Date signed

_____ _____
Witness's signature (*If applicant signs with an X*) Date signed

HIV/AIDS Branch
Please forward this application to:

Dept for Public Health
275 East Main Street, HS2E-C
Frankfort, KY 40621-0001
Secured FAX (877)353-9380

Office Use Only:

Application approved by:

_____ _____
Name Date approved

Statement of No Income

I, _____, declare that I currently have zero income. I am
(print your name)
meeting my daily living needs by _____

_____

_____.

In the future, should I receive income, either through employment, Supplemental Security Income (SSI), Social Security Disability, or other means, I understand that I must notify the State Ryan White Part B Services Program immediately.

I understand I will be notified by mail if changes in my income affect my eligibility for services.

_____ _____
Client Signature Date

_____ _____
Witness (if client is unable to sign) Date

HIPAA: AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

Section A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my individually identifiable information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or a health care provider, that the organization may also disclose my health information. If this happens, I understand that my information may no longer be protected by federal privacy regulations.

Patient name:_____ ID Number: _____

Persons/Organizations authorized to release/receive information includes: **(Agency Name)**
Persons/Organizations authorized to exchange information includes: **Division of Epidemiology and Health, Planning, Department for Public Health, HIV/AIDS Branch, Medicare/Medicaid**

Specific description of information to be disclosed (including date(s)): progress notes, Medical Documentation Form, medical history, laboratory test results, medication history, discharge summaries, treatment recommendations..

1. **The patient or the patient's representative must read and initial the following statements:**
   a) I specifically authorize the (Agency Name) to release to _____ _____ data and information relating to:
      - **Substance Abuse** (alcohol/drug testing & treatment) Initials:_____
      - **Mental Health** (psychological testing & treatment) ___ Initials:_____
      - **HIV-Related Information** (testing & treatment) Initials:_____

   b) I understand that this authorization will expire _____ Initials:_____
   c) I understand that I may revoke this authorization at any time by notifying the (Agency Name) in writing. If I do revoke this authorization, my revocation will not have an effect on any actions the (Agency Name) took in reliance upon my authorization before it received my revocation. Initials:_____

2. **To be completed by the Case Manager/Care Coordinator (check only one):**

a) (Agency Name) will not condition your services on your completing and signing this authorization. ☐
b) (Agency Name) will condition and not provide services to you because you are not in compliance with Program Guidelines. ☐

Section B: Must be completed when the (Agency Name) requests the authorization for its own use or for another covered entity to disclose information to the (Agency Name) for services.

To be completed by (Agency Name):

1. The purpose of the use or disclosure is: to provide case management services.

2. (Agency Name) ☐ will not receive direct or indirect compensation in exchange for using or disclosing the information listed above.

NOTICE TO PATIENT: You or your representative may inspect and/or copy your individually identifiable information in accordance with (Agency Name) policies and procedures.

Section C: Must be completed for all authorizations.

Patient Name: (print**)**_____ **Patient Social Security Number:**_____

_____ _____
Signature of patient or patient's representative **Date**

Printed name of patient's representative: _____

Witness:_____ **Date:**_____

Informed Participation Agreement

Description of Ryan White Services Program:
Administered by the HIV/AIDS Branch within the Division of Epidemiology of the Kentucky Department for Public Health, the Ryan White Services Program is more than a drug distribution program, or a program that pays for insurance or medical care. The Ryan White Services Program provides a comprehensive system of care that includes medication, medical care and essential support services for people living with HIV who are low income and uninsured or underinsured.

Benefits and Entitlement Counseling:
Case Managers and Benefits Counselors can assist eligible clients to obtain access to Kentucky's AIDS Drug Assistance Program, the Health Insurance Continuation Program, the Home Health Care Program, and the Kentucky HIV Care Coordination Program which provides access to an array of medical and support services. The Case Managers and Benefits Counselors will obtain the completed application, supporting documentation, and any insurance information for the client wishing to receive these services.

Client Responsibilities:
Client must provide accurate information and required documentation to complete the initial, and semi-annual application for eligibility certification. The client must report any changes in residency or household income immediately.

Disenrollment Policies:
Client will be dis-enrolled from the Ryan White Services Program if they:

- Fail to recertify before the designated expiration date;
- Are lost to Follow-up;
- Commit Fraud by knowingly and willingly withholding, hiding, or falsifying information in order to qualify and/or remain eligible the Ryan White Services Program.

When a client is dis-enrolled from the Ryan White Services Program due to violation of program rules or regulations**,** the provider agency must document:

- The violation;
- The duration of the suspension;
- The mechanism of re-instatement; and
- Providing the patient with a verbal and written description of the appeal process.

No eligible client(s) may be dis-enrolled from the Ryan White Services Program without the express approval of the State Ryan White Part B Staff and the HIV/AIDS Program Branch Manager.

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Client Eligibility Guidelines:

Clients are required to provide proof of, or in some instances attest to, the following eligibility requirements:

- Being HIV infected;
- Having a household income below 500% of the Federal Poverty Guidelines; and
- Being a resident of the Commonwealth of Kentucky

Individuals not eligible for the Ryan White Services Program include:

- Non-residents of the State of Kentucky;
- Non-HIV positive individuals; and
- Individuals with an income greater than 500% FPL.

Your signature below confirms your intent to participate in the Kentucky HIV/AIDS Branch's, Ryan White Services Program, and that you understand that you must adhere to all policies and guidelines set forth in the Informed Participation Agreement (IPA). You further acknowledge that you received and reviewed a copy of the IPA.

_____ _____
Signature of Client or Designated Representative **Date**

_____ _____
Signature of Care Coordinator **Date**

If a Designated Representative is indicated above, complete the following section:
(Please Print)

Name of Representative_____

Mailing Address_____

Phone Number_____

Client's Initials_____

No Change/Report of Change Form

I, _____, declare that there has been a change in my;
(print your name)

- ○ **Medical Insurance**
- ○ **Income**
- ○ **Household size**
- ○ **KY residency (address)**
- ○ **No Changes**

If you <u>HAVE</u> experienced a change in any of the items listed above, please complete the section of this form that applies to your situation. Sign and date this form at the bottom of the page, and return it to the address below:

A. Insurance Coverage Change:

____ My insurance information has changed. ____ My insurance coverage has expired.

<u>A copy (both front and back) of my new health insurance card is attached to this form</u>. Additional insurance information is listed below:

Insurance company: _____ Policy #:_____ Date Active:_____

B. Income change:

_____ I have experienced a change in household income. My new household income is $_____ per month. This change was effective on _____. . **Please provide proof of this income**.

C. Household size change:

_____ I have experienced a change in household size and realize that this change **may affect** my eligibility for Ryan White Program services. There are now _____ persons in my household, including ____ persons under the age of 18, as of _____.

D. Address change:

_____ I have moved. My new address is: _____

City_____ State____ Zip_____ **Please provide proof of this address.**

Care Plan Review:

_____I have read/reviewed, understand, and agree with the Care Plan that is documented in my medical record. I agree to carrying out the tasks assigned to me to the best of my ability.

_____ I do not wish to participate in the Case Management program at this time.

Client signature: _____Date: _____

Mail/Submit form to: Eligibility Coordinator, Dept. for Public Health, 275 E. Main Street, HS2E-C, Frankfort KY 40621-0001

Grievance Procedures

A. Types of grievances

Consumers may express their dissatisfaction with any Ryan White Services Program service in the following manner:

B. Grievance Procedures

1. The client should discuss the problem directly with the Case Manager/Care Coordinator or counselor at the service site the problem/incident occurred within five (5) working days of the incident or time when client/individual became aware of the problem/incident. For accurate record keeping, please record the date and time this discussion occurred, along with the name of the person the problem/incident was discussed with, as this information may prove helpful later.

   If client is not satisfied with the decision, the client may forward all written materials within twenty (20) working days after receiving the decision/response to the Kentucky HIV/AIDS Branch, Section Supervisor:

   275 East Main St
   Mail Stop HS2E-C
   Frankfort, KY. 40621-0001
   1-800-420-7431

2. A response will be made in writing within ten (10) working days of receiving the grievance materials.

3. If not satisfied with the HIV/AIDS Section Supervisor's response, the client/individual may forward all written materials within twenty (20) working days after receiving the decision/response to the HIV/AIDS Branch Manager:

   275 East Main St.
   Mail Stop HS2E-C
   Frankfort, KY. 40621-0001

4. The Branch Manager will respond in writing within ten (10) working days of receiving the written materials.

5. If not satisfied with the HIV/AIDS Branch Manger's response, the client/individual may forward all written materials within twenty (20) working days after receiving the decision/response to the Kentucky Department of Public Health, Division of Epidemiology & Health Planning Director at:

   275 East Main Street
   Mail Stop HS2GWC
   Frankfort, KY 40621-0001

   The decision by the Director of the Division of Epidemiology & Health Planning Director is final.

Client Signature: _____ Date: _____