RYAN WHITE SERVICES ELIGIBILITY APPLICATION

KADAP (Kentucky AIDS Drug Assistance Program)
KHICP (Kentucky Health Insurance Continuation 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 Section prior to receiving the services. The only exception is 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, valid driver's license or official state ID that includes current address, other official mail, or 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 does not have the required Proof of Residency documentation, can complete a **Residency Self-Attestation Form** including the city, state, and zip code.

- **Proof of Income**
  You MUST submit one of the following: most recent W-2, 2 recent paycheck stubs, Social Security statement, unemployment check/letter, workman's compensation letter, or if self-employed completed tax return. Please provide proof of income for all amounts listed. All documents provided, except for Social Security statement, must be LESS than 6 months old. An individual who does not have the required Proof of Income documentation, can complete an **Income Self-Attestation Form** including the sources of income and gross amounts.

- **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. An individual who does not have the required Proof of Insurance documentation, can include this information on the insurance portion of the Eligibility Application. If uninsured, you must vigorously pursue insurance benefits or document with your initial application your refusal to participate in an insurance benefits program.

- **Proof of Positive HIV Status**
  Provide a complete name-linked verification of HIV positive status. The following items may be used to verify HIV status: 2 reactive rapid HIV tests conducted on the same day, a positive signed and dated Clinical Information Form (CIF), a testing counselor who has been certified by the Centers for Disease Control and Prevention (CDC) training "Implementing HIV Testing in Non-clinical Settings" 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:

- ☐ Completed Application
- ☐ Informed Participation Agreement (IPA) Form
- ☐ Grievance Procedures Form
- ☐ Health Insurance Portability and Accountability Act (HIPAA) Release of Information Form/Self-Attestation Form(s)
- ☐ Proof of Eligibility Requirements
- ☐ Proof of Status (Initial Application)/Clinical Information Form (Annual Recertification)

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*
- ☐ Clinic Information Form (CIF)

*For Report of Change, include supporting documentation.

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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: Department for Public Health, 275 East Main Street, HS2E-C, Frankfort, KY 40621-0001. Secured fax (877)353-9380.

1. Applicant Information:

Applicant name:_____

_____

Physical address (street address): _____

City: _____ State: _____ Zip: _____

Mailing address (street name 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: ( ) _____ _____ Sex at birth: _____

Describe gender identity: _____ Race/ethnicity: _____

NOTE: We may have to call you at 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

____ No 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 ____

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	$_____	$_____	$_____
Other:	$_____	$_____	$_____
TOTAL:	**$_____**	**$_____**	**$_____**

*** 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 Program 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 HIPAA. Some information in this application will be supplied to the Medicare/Medicaid office to determine if the client meets medically frail criteria. Medically frail classification will exempt the client from any obligations that may be required to maintain coverage and 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, residency, 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 Section
Please forward this application to:
Department 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 _____

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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:
_____
Persons/Organizations authorized to exchange information includes: **Department for Public Health, Division of Epidemiology and Health Planning, Infectious Disease Branch, HIV/AIDS Section, 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 _____ (Agency Name) to release to _____ data and information relating to:
      - **Substance Abuse** (alcohol/drug testing and treatment) Initials:_____
      - **Mental Health** (psychological testing and treatment) Initials:_____
      - **HIV-Related Information** (testing and treatment) Initials:_____

   b) I understand that this authorization will expire (date) _____ Initials:_____
   c) I understand that I may revoke this authorization at any time by notifying _____ (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 _____ (Agency Name) requests authorization for its own use or for another covered entity to disclose information to _____ (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): _____Social Security Number: _____

Signature of patient or patient's representative:_____ Date: _____
Name of Patient Representative (print): _____
Witness:_____Date:_____

Informed Participation Agreement

Description of Ryan White Services Program:

Administered by the HIV/AIDS Section within the Infectious Disease Branch of the Division of Epidemiology and Health Planning 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 with HIV who are low income, 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:

- To be treated with consideration, dignity, and respect regardless of age, race, gender identity, economic status, sexual orientation, mode of transmission, disability status, mental status, family status, nationality, ethnic origin, religious beliefs, or political affiliations.
- To treat HIV/AIDS staff with consideration, dignity, and respect.
- 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.

Dis-enrollment Policies:

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

- Fail to recertify before the designated expiration date;
- Do not meet eligibility requirements;
- Are lost to follow-up; or
- Commit fraud by knowingly and willingly withholding, hiding, or falsifying information in order to qualify and/or remain eligible in 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
- Provision to the patient the 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 written approval of the State Ryan White Part B Staff and/or the HIV/AIDS Ryan White Supervisor.

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Client Eligibility Guidelines:

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

- HIV positive status;
- Household income; and
- Resident of the Commonwealth of Kentucky.

Individuals not eligible for the Ryan White Services Program include:

- Non-residents of Kentucky and
- HIV negative individuals.

Your signature below confirms your intent to participate in the Kentucky HIV/AIDS Section, 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 Initials_____

Grievance Procedures

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

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 Ryan White Services Program Manager and/or Kentucky HIV/AIDS Section Medical Director:

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

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

3. If not satisfied with the Kentucky Ryan White Services Program Manager's response, the client/individual may forward all written materials within twenty (20) working days after receiving the decision/response to the HIV/AIDS Section Medical Director:

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

4. The HIV/AIDS Section Medical Director will respond in writing within ten (10) working days of receiving the written materials.

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

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

   The decision by the Infectious Disease Branch Manager is final.

Client Signature: _____ Date: _____

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Residency Self-Attestation Form

I, _____, declare on this date_____ that I currently reside at
(print name)

Street: _____

City: _____

State: _____

Zip Code: _____

☐ The above address is both my physical address and mailing address.

☐ The above address is my physical address, but I receive mail at the following alternate address:

_____

☐ I currently do not have a permanent address and am residing at one of the following:

___ a supervised publicly operated shelter designed for temporary living accommodations.

Name of Shelter _____

___ another public or private place (friend) not designed for, or ordinarily used as a regular sleeping accommodation.

Specify Place _____

☐ Homeless living in the following city and state:

_____

In the future, should there be a change with any of the aforementioned criteria, I understand that I must notify the Ryan White Services Program immediately with attached supporting documentation.

I understand I will be notified by the Ryan White Services Program if any changes affect my eligibility.

_____ _____
Client Signature Date

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

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Income Self-Attestation Form

Please check all that apply.

☐ I, _____, declare that I currently have zero income. I am meeting my daily
(print name)

daily living needs by _____.

☐ I, _____, declare that my spouse/partner currently has zero income.
(print name)

☐ I, _____, declare that I receive monthly income from _____
(print name) (source of income)

In the gross amount of $_____.

☐ I, _____, declare that my spouse/partner receives monthly income from
(print name)
_____ in the gross amount of $_____.
(source of income)

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) Datw

08/31/2022