For office use only: Date Received: _____ MR#:_____

Nebraska Ryan White Program

Application Information

Date: _____

Check all the programs applying for:
☐ Part B ☐ Part C ☐ Part D ☐ ADAP ☐ ADAP co-payment assistance ☐ Wait list

If you live in Iowa, are you eligible for Iowa ADAP? ☐ Yes ☐ No ☐ Pending ☐ Wait list
If yes, eligibility date: _____

Checklist

Include the following documents with your completed application.

☐ Proof of income for yourself

☐ Proof of income for your spouse

☐ Proof of income for your dependents

☐ Copy of your health insurance card(s)

☐ Copy of your prescription drug plan card

☐ Copy of page 1 of your 2012 U.S. tax return, if filed

☐ Signed 4506-T form, if taxes not filed or unable to provide copy of your return

Applicant Information

Name		
Last Name	First Name	MI
Social Security Number	Birth date	
Gender: ☐ Male ☐ Female ☐ Transgender ☐ Male to Female ☐ Female to Male		

Residential Address (where you live)		
Street	City	
State	Zip Code	County
May we contact you at this address? ☐ Yes ☐ No		

Mailing Address Check here if same as residential address ☐		
Street	City	
State	Zip Code	County
May we contact you at this address? ☐ Yes ☐ No		

Telephone		
Home number: _____	May we call you? ☐ Yes ☐ No	
Cell number: _____	May we call you? ☐ Yes ☐ No	

Ethnicity	
☐ Hispanic ☐ Non-Hispanic	

Race	
☐ White	☐ Black or African American
☐ Asian	☐ American Indian/Alaska Native
☐ Native Hawaiian/ Pacific Islander	☐ Other: _____

Primary Language			
☐ English	☐ Spanish	☐ Other: _____	☐ Need translation services

Citizen Status	
Are you a U.S. Citizen? ☐ Yes ☐ No If no, then are you a Legal Resident? ☐ Yes ☐ No Date of Legal Resident status: _____ Refugee ☐ Yes ☐ No	Country of Origin: _____

Marital Status				
☐ Single	☐ Married	☐ Divorced	☐ Widowed	☐ Partnered

Housing Status				
☐ Rent	☐ Living with family/friend	☐ Mortgage	☐ Homeless	☐ Other: _____

Emergency Contact			
Name	Aware of HIV status ☐ Yes ☐ No		
Relationship to applicant	Phone number		
Street address	City	State	Zip

Household

Complete the following table with information for your spouse and dependent children.
Attach additional sheets if necessary.

Full Name	Relationship	Gender	Age	Aware of HIV Status?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Income

List monthly gross income information for yourself and any other household members for whom you are financially responsible.

Full Name	Relationship	Birth Date	Income Source	Monthly Gross Amount
Applicant	Self			$
				$
				$
				$
				$
				Total: $_____

You must provide a copy of page 1 from your most recent U.S. income tax return. If you do not have a copy, then you must provide a copy of the following for you, your spouse and/or dependents:

- Last pay stub (not older than 30 days)
- Unemployment benefits statement
- Social Security Disability or Supplemental Security Income (SSI)
- Social Security Retirement, Survivor or Children Insurance Benefits
- Spousal (alimony) support
- Retirement or pension benefits (veterans, military, and commercial plans)
- Commercial short-term or long-term disability benefits
- Rental income
- Investments (interest, dividends, annuities, royalties, trusts)
- Worker's Compensation
- Other - such as Aid to Dependent Children (ADC)

If you do not have any income, then complete and sign the No Income Verification form on page 7.

If you do not have a copy or did not file a tax return, then complete and sign a 4506-T form.

Check the box next to why you did not file a tax return.

☐ Did not earn enough to be required to complete tax return
☐ Only income is Supplemental Security Income (SSI)
☐ I owe the government money I cannot pay (for example, owing back child support)
☐ I do not know how to file a tax return
☐ Other: _____

Health Insurance

Medicaid – ☐ Check box if not enrolled in Medicaid

Check the Medicaid program in which you are enrolled. Provide copy of your Medicaid card.

☐ Medicaid - disability
☐ Medicaid with spend down: Spend down amount $_____
☐ Medicaid - pregnant
☐ Medicaid for Families & Children
☐ Qualified Medicare Benefit (QMB or SLMB)
☐ Iowa's Medicaid program

Medicare – ☐ Check box if not enrolled in Medicare

Check all of the Medicare programs in which you are enrolled. Provide copy of your Medicare card.

☐ Covered under Part B (outpatient)
☐ Covered under Part D (prescription plan)
Plan name:_____

Private Health Insurance – ☐ Check box if not enrolled in private health insurance

Check the private health insurance program in which you are enrolled.
Provide copy of health insurance and prescription drug card.

☐ Plan through my employer
☐ My employer offers health insurance, but I do not participate
☐ Through a retirement plan
☐ I am unsure if I am eligible for or covered by private health insurance
☐ Under COBRA which expires on ____/____/_____
☐ Under someone else's policy (spouse, partner, parent)
☐ Individual health insurance policy (self-insured)

Does your private insurance cover dental? ☐ Yes ☐ No

Does your private insurance cover vision? ☐ Yes ☐ No

If you are eligible for health insurance, but are not currently covered, explain why:

Medical

HIV Clinical Information

☐ AIDS diagnosis ☐ HIV + (not AIDS) ☐ HIV+ (AIDS status unknown)

HIV diagnostic date: _____/_____/_____ State residing when diagnosed with HIV: _____

AIDS diagnostic date: _____/_____/_____ State residing when diagnosed with AIDS: _____

Exposure category:

☐ Men who have sex with men ☐ Heterosexual contact ☐ Receipt of blood transfusion, blood components, or tissue
☐ Injection drug use ☐ Perinatal transmission

Most recent CD4 Count:	Date	Most recent Viral Load:	Date

HIV Doctor	Provider Clinic	Provider Telephone

When were you last seen by an HIV/AIDS specialist? _____/_____/_____

When is your next appointment with an HIV/AIDS specialist? _____/_____/_____

Are you currently taking HIV medications? ☐ Yes ☐ No

If yes, date started taking: _____

Nebraska Ryan White Programs Consent

I, _____, understand the following:
(Print name)

1. The standards for eligibility and participation in the Ryan White CARE Act funded programs are the same for everyone regardless of race, color, national origin, age, disability or gender**.**

2. This program involves the receipt of federal funds. The Nebraska Department of Health and Human Services Ryan White Part B Program/AIDS Drug Assistance Program, the University of Nebraska Medical Center Ryan White Part C and D Programs, and the Western Community Health Resources Panhandle Ryan White Part C Program reserve the right to limit or deny services in order to adhere to the budgetary limitations of the Program.

3. I hereby grant permission for the exchange of information amongst the Program Coordinators, Nebraska AIDS Project Case Managers, care providers, the Nebraska Department of Health and Human Services, the University of Nebraska Medical Center, the Western Community Health Resources and/or the Iowa Ryan White Program regarding this application and all items related to the application, as it relates to Ryan White CARE Act funded services. I understand that information will not be released to any person or entity not included in this agreement without my consent.

4. I hereby give authorization to allow the release of information including but not limited to financial billing information as it pertains to my care to the Nebraska Department of Health and Human Services, Ryan White Part B Program, AIDS Drug Assistance Program, The University of Nebraska Medical Center Ryan White Part C and D Programs, and/or the Western Community Health Resources Ryan White Part C Program. I understand this information will be used to evaluate my care and provide statistical data pertaining to program evaluation and quality assurance activities.

5. I agree to promptly notify the applicable Program Coordinator/Case Manager/Provider if I have any life changing events that may impact my eligibility for Ryan White CARE Act funded services. Including but not limited to a change in my address, living situation, physician/care provider, Medicaid/Medicare/private insurance status, residency/immigrant status, financial status, I understand that I must apply every six months for ADAP and annually for Ryan White Part B, Part C and Part D program services to determine my eligibility.

6. I certify all the statements made on all parts of this registration are true and complete to the best of my knowledge. I realize that falsification of information may subject me to immediate ineligibility of participation for Ryan White services.

_____

Applicant signature Date

_____

Case manager signature (if assisted with application) Date

Nebraska Ryan White Programs - No Income Verification

Complete the following form only if you do not have any income.

I, _____, am applying for assistance through the Nebraska Ryan White Part B Program, the AIDS Drug Assistance Program (ADAP), Western Community Health Resources Panhandle Ryan White Part C Program and/or the University of Nebraska Medical Center Ryan White Part C or Part D programs. I am aware that all of the Ryan White Programs require verification of all income and if I do not have an income then I must complete this verification form.

I have stated during this application process that I do not have income at this time.

I have not received income since _____.

I do not expect to receive income until _____.

I understand that should my financial situation change, I am required to notify the Ryan White Programs or my case manager immediately.

At this time I am financially being provided for (food, shelter, utilities, clothing, etc.) in the following way:

_____

_____

_____

_____

_____

I verify that all statements regarding my financial situation and how I am provided for are true.

_____

Applicant signature Date