

## Ryan White Part A Registration Letter

Thank you for your recent registration and interest in receiving Ryan White Part A services. The Ryan White Part A HIV/AIDS Program is a federal program that addresses the unmet health needs of persons living with HIV/AIDS (PLWH/A) by funding primary health care and support services that enhance access to and retention in care.

The eligibility process for this program begins today, \_\_\_\_\_. Your eligibility begin date is \_\_\_\_\_ and your eligibility end date is \_\_\_\_\_. It is your responsibility to schedule an appointment by \_\_\_\_\_ for you eligibility redetermination.

If you have any questions about your eligibility approval, please contact:

\_\_\_\_\_ at \_\_\_\_\_  
Agency Name/Phone Number

It is important to stay connected. Please report any changes to your registering agency. These changes may include your address, telephone number, financial needs, living arrangements, services needs or physicians name. Thank you again for your interest in Ryan White Part A services.

\_\_\_\_\_  
Client's Signature Date

\_\_\_\_\_  
Parent or Guardian Date

\_\_\_\_\_  
Registering Agency Staff Member Date

## Ryan White Part A Eligibility Documents

Name: \_\_\_\_\_ URN: \_\_\_\_\_ Date: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Eligibility Specialist Reviewing: \_\_\_\_\_

Documentation from each category must be attached to this document and easily located in the client file for each initial registration and six month reassessment on all Part A clients.

<b>Proof of Identification (Photo ID Required)</b>	
	Nevada or Arizona Exp Date : _____
	Passport/Foreign Country ID Exp Date: _____
	INS papers/Permanent Resident Card
	Social Security Card (in conjunction with picture ID)
	Government issued ID Card
	Baptismal Certificate
	Birth Certificates of children in household
	Birth Certificate (in conjunction with picture ID)
	Other: _____

<b>Proof of Diagnosis (Required for newly registered clients only)</b>	
	Western Blot
	Quantitative Viral Load
	Physicians Letter on letterhead signed by M.D. with at least one (1) of these items:
a.	Indication client is receiving treatment for HIV/AIDS
b.	Statement of quantitative viral load

<b>Proof of Residency (2 forms required)</b>	
	Lease Agreement
	Rent/Mortgage Receipt
	Utility Bill
	Statement of Living Arrangements
	Letter from a Government Agency
	Voter Registration/Vehicle Registration
	Prison Release Papers
	Other: _____

<b>Proof of Income (Submit at least one dated within the last 90 days)</b>	
	Pay stubs for the most recent 90 day period
	Social Security Statement (most recent)
	VA Benefits
	Recent Tax Return
	Statement of no income
	Statement of unemployment benefits
	Statement of child support
	Statement of cash assistance
	Bank statements with direct deposits
	Pension statement
	Statement of support from family/friend
	Other: _____

<b>Medical Insurance</b>	
	Medicare/Medicaid
	Statement of Cobra Insurance
	CCSS Medical Card
	VA Card
	Private Insurance
	AHCCS Card (Arizona Residents)
	<b>Pending</b>
	SSI/SSD/Medicaid

<b>Asset Verification</b>	
	Bank Statement (last month's statement)
	Vehicle registration
	Statement of retirement funds
	Life insurance policy (with cash value)
	Tax refunds
	Lump sum awards for the last 12 months (excluding S.S. lump sums or IRS refunds)
	Real estate holdings
	Proof of asset spend down (receipts)

Date: \_\_\_\_\_

Clients Signature: \_\_\_\_\_

## Ryan White Part A Client Registration Form

Today's Date:	Client URN:	Does the client need an interpreter: <input type="checkbox"/> Yes <input type="checkbox"/> No If so, what language:
<input type="checkbox"/> Newly Diagnosed or New to Care <input type="checkbox"/> Returning Client (out of care for 12 months or more)		Assigned Case Manager:
<b>DEMOGRAPHICS</b>		
Last Name:		Middle Name:
First Name:		
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender (male to female) <input type="checkbox"/> Transgender (female to male) <input type="checkbox"/> Transgender (Unk) <input type="checkbox"/> Unknown	Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Non-Latino <input type="checkbox"/> Unknown/Unreported	Race: <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Multi-Racial
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Domestic Partner		
Date of Birth:    /    /    ( <input type="checkbox"/> check if estimated)	Age:	Social Security Number:
Home Address:		Apt #    City:
State:	County:	Zip Code:
<input type="checkbox"/> check if same as home address Mailing Address:		Apt #    City:
State:	County:	Zip Code:
May we contact you by mail at this address? <input type="checkbox"/> Yes, contact via mailing address <input type="checkbox"/> No		
Home phone#: (    )		Other phone#: (    )
May we leave you a message at this phone number? <input type="checkbox"/> Yes, contact via home phone # <input type="checkbox"/> Yes, contact via other phone # <input type="checkbox"/> No		
Have you ever served in the military? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, please list your dates of services: _____ to _____		
What is your primary source of transportation: <input type="checkbox"/> Own a car <input type="checkbox"/> Public Transportation (bus) <input type="checkbox"/> Friends/relatives <input type="checkbox"/> Walking <input type="checkbox"/> Other: _____		

### HIV/AIDS STATUS AND MEDICAL INFORMATION

What is your HIV/AIDS status: <input type="checkbox"/> HIV-positive (not yet AIDS) <input type="checkbox"/> HIV-positive (AIDS status unknown) <input type="checkbox"/> AIDS <input type="checkbox"/> HIV-negative (affected) <input type="checkbox"/> Unknown <input type="checkbox"/> HIV-indeterminate (only if under 2 years of age)	How were you infected with HIV/AIDS: <input type="checkbox"/> Male to Male sexual contact <input type="checkbox"/> Injection Drug Use <input type="checkbox"/> Hemophilia/Coagulation Disorder <input type="checkbox"/> Heterosexual Contact <input type="checkbox"/> Perinatal Transmission <input type="checkbox"/> Undetermined/Unknown, risk not reported or identified <input type="checkbox"/> Recipient of transfusion of blood, blood components, or tissue <input type="checkbox"/> Other, please specify: _____
HIV Diagnosis Date: ( <input type="checkbox"/> check if estimated)	AIDS Diagnosis Date: ( <input type="checkbox"/> check if estimated)
Who is your Primary HIV Medical Provider or where do you go for HIV medical care:	
Location name:	
Results of your most recent Viral Load:	What is the date of that Viral Load:

Results of your most recent CD4 Count:	What is the date of that CD4 Count:
Are you currently taking any prescribed medications? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes If so, what medications are you taking:	
Who is your primary insurance provider: <input type="checkbox"/> Medicaid/AHCCCS <input type="checkbox"/> Medicare <input type="checkbox"/> No Insurance <input type="checkbox"/> Other, please specify: _____ <input type="checkbox"/> Other public (e.g. Champus, VA) <input type="checkbox"/> Private Insurance <input type="checkbox"/> Unknown	Other Insurance (if any): <input type="checkbox"/> Medicaid/AHCCCS <input type="checkbox"/> Medicare <input type="checkbox"/> No Insurance <input type="checkbox"/> Other, please specify: _____ <input type="checkbox"/> Other public (e.g. Champus, VA) <input type="checkbox"/> Private Insurance <input type="checkbox"/> Unknown

EMERGENCY CONTACT INFORMATION			
Contact name:	Relationship to you:		
Address:	City:	State:	Zip Code:
Home phone#: (      )	Other phone#: (      )	Is this contact aware of your diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No	

EMPLOYMENT AND ASSET INFORMATION	INCOME INFORMATION	
What is your current occupation:	List below all income you and those living in your household-including spouses, domestic partners and any dependents that could be claimed on your taxes-receive from the following sources on a monthly basis:	
Who is your current employer:		
Do you have any assets (savings, CD, cash, ect.)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If so, what is the total amount of those assets? \$		
Do you own a home or other property? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you own more than one registered vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No	Alimony \$	
<b>CURRENT SERVICE NEEDS</b>		Child Support \$
What services are you in need of today, (please check all that apply):	Wages from Employment \$	
<input type="checkbox"/> Housing Assistance <input type="checkbox"/> Employment Assistance	Food Stamps \$	
<input type="checkbox"/> Emergency Financial Assistance <input type="checkbox"/> Food Bank	State Disability Insurance/SDI \$	
<input type="checkbox"/> Support Groups <input type="checkbox"/> HIV/AIDS Information	Long-Term Disability/LTD \$	
<input type="checkbox"/> Individual Counseling <input type="checkbox"/> Vision Care	VA Benefits \$	
<input type="checkbox"/> Nutrition Therapy <input type="checkbox"/> Transportation Assistance	Supplemental Security Income/SSI \$	
<input type="checkbox"/> HIV/AIDS Medical Provider <input type="checkbox"/> Substance Use Treatment/Counseling	Social Security Disability Income/SSDI \$	
<input type="checkbox"/> HIV/AIDS Medication <input type="checkbox"/> Mental Health Treatment/Counseling	Social Security Retirement \$	
<input type="checkbox"/> Assistance with Medication Co-Pays <input type="checkbox"/> Eligibility for Ryan White Services	TANF \$	
<input type="checkbox"/> Other:	Retirement \$	
	Gifts \$	
	Other (specify): \$	
	<b>Total Monthly Household Income</b> \$	
	<b>Total Annual Household Income</b> \$	

**LIVING STATUS AND RELATIONSHIP INFORMATION**

What is your current living /housing arrangement:  
 Stable/Permanent       Unstable  
 Other: \_\_\_\_\_       Institution  
 Non-permanently housed

How many people live with you:

Please list everyone who lives with you in the provided space below.

<i>Name</i>	<i>Relationship to you</i>	<i>Gender</i>	<i>Date of birth</i>
			( <input type="checkbox"/> check if estimated)
			( <input type="checkbox"/> check if estimated)
			( <input type="checkbox"/> check if estimated)
			( <input type="checkbox"/> check if estimated)
			( <input type="checkbox"/> check if estimated)
			( <input type="checkbox"/> check if estimated)
			( <input type="checkbox"/> check if estimated)

**ADDITIONAL REFERRALS**

Please list any additional referrals (not listed above) provided to the client for Ryan White or non-Ryan White Community Resources.

<i>Service Needed:</i>	<i>Organization Referred to:</i>

**CASE MANAGEMENT NOTES**

If documented in CAREWare or another location please specify.

- Client agrees to participate in Case Management Services.
- Client elects not to participate in the program at this time.
- Client is not eligible for Ryan White Part A and will be referred to resources they are eligible for.

Today's Date: \_\_\_\_\_

Case Managers Signature: \_\_\_\_\_

Next Eligibility Redetermination Date: \_\_\_\_\_

The Case Management Program has been explained to me and any questions I had have been answered. I agree to participate in Case Management Services.

Today's Date: \_\_\_\_\_

Clients Signature: \_\_\_\_\_

Parent or Guardian Signature: \_\_\_\_\_

## Ryan White Part A Medical Case Management Screening Tool

Please attach to client registration or reassessment form

Today's Date:	Client URN:	Assigned Case Manager:	
Last Name:		First Name:	Middle Name:

### HIV/AIDS MEDICAL APPOINTMENT ADHERENCE SCREENING

1. Does the client have an HIV/AIDS Medical Provider?  Yes  No (provide referral)  Just entering the care system (provide referral)

2. Date of last medical appointment? \_\_\_\_\_ Date of next medical appointment? \_\_\_\_\_

3. Does the client have a copy of current labs (maximum of 6 months from today's date)?  Yes  No

4. Please check all of the barriers to medical care that the client mentions:

<input type="checkbox"/> Just entering the care system	<input type="checkbox"/> Not ready to access care	<input type="checkbox"/> Afraid
<input type="checkbox"/> Homelessness	<input type="checkbox"/> Doesn't want to deal with it	<input type="checkbox"/> Feels fine/no symptoms
<input type="checkbox"/> Doesn't know where to go	<input type="checkbox"/> Couldn't get an appointment	<input type="checkbox"/> Drugs/Alcohol in the way
<input type="checkbox"/> Doesn't think it will help	<input type="checkbox"/> Clinic hours aren't convenient	<input type="checkbox"/> Child care unavailable
<input type="checkbox"/> Don't want people to know	<input type="checkbox"/> Doesn't like the doctors there	<input type="checkbox"/> No transportation
<input type="checkbox"/> Language barriers	<input type="checkbox"/> Lack of proper identification	<input type="checkbox"/> Other, please specify:

Please assess and work with clients to diminish barriers to care.

Referral provided for medical care?  Yes  No  Client Refused

If yes, where: \_\_\_\_\_

Clients must be referred for medical care if they do not currently have a medical provider or if they don't have current labs (dated no more than 6 months prior to the current appointment).

Notes:

### HIV/AIDS MEDICATION ADHERENCE SCREENING

1. Is the client currently prescribed HIV/AIDS medication?  Yes  No

2. Does the client currently take their medication?  Yes  No  Sometimes

3. How many doses has the client missed in the last month?  0  1  2 or more

If client reports missing doses please ask them why, (check all that apply):

<input type="checkbox"/> Doesn't want to deal with it/take meds	<input type="checkbox"/> Lack of social support	<input type="checkbox"/> Alcohol and/or Drug Use/Abuse
<input type="checkbox"/> Side effects	<input type="checkbox"/> Doesn't think meds work	<input type="checkbox"/> Medication regimen too complex
<input type="checkbox"/> Depression/Mental Health issues	<input type="checkbox"/> Can't get refills in time	<input type="checkbox"/> Alcohol and/or Drug Use/Abuse
<input type="checkbox"/> Too many pills	<input type="checkbox"/> Taste of medication	<input type="checkbox"/> Other:

Please assess and work with clients to diminish barriers to care.

Counseling provided or referral provided for Medication Adherence Counseling?  Yes  No  Client Refused

If yes, where : \_\_\_\_\_

Notes:

### NUTRITION SCREENING

1. What is your current weight and height? \_\_\_\_\_ feet \_\_\_\_\_ inches \_\_\_\_\_ weight

2. Without wanting to, have you experienced significant weight loss in the last 6 months?  Yes  No

3. Are you being treated for medical issues in addition to HIV, such as; diabetes, kidney disease, liver disease/hepatitis, high cholesterol/heart disease, hypertension, cancer, anemia, depression?  Yes  No  Other: \_\_\_\_\_

4. Are you experiencing any extreme side effects from your medication such as vomiting, diarrhea or poor appetite (little or no desire to eat)?  Yes  No

5. Do you have access to food?  Yes  No

Referral provided for Medical Nutrition Therapy or other food provider?  Yes  No  Client Refused

If yes, where: \_\_\_\_\_

Notes:

#### CAGE SUBSTANCE/ALCOHOL ABUSE SCREENING

Is the client currently in any kind of treatment for substance or alcohol use (includes meeting with a psychologist or counselor, attending group sessions)?

Yes (stop here)  Never used either substance (stop here)  No (complete screening)

1. During the **past month**, have you felt you ought to cut down on your drinking or drug use?  Yes  No

2. During the **past month**, have people annoyed you by criticizing your drinking or drug use?  Yes  No

3. During the **past month**, have you felt bad or guilty about your drinking or drug use?  Yes  No

4. During the **past month**, have you had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hang-over-eye-opener?  Yes  No

If the client answered "yes" to any of the above substance abuse screening questions a referral for substance abuse treatment is strongly encouraged.

Referral provided for Substance or Alcohol abuse?  Yes  No  Client Refused

If yes, where: \_\_\_\_\_

Notes:

#### EVALUATION OF MENTAL HEALTH DISORDERS SCREENING TOOL Questions taken from the Primary Care Evaluation of Mental Disorders Screening Tool

Is the client currently being treated for a mental health problem (includes professional help from psychologist or counselor, attending group therapy sessions taking medication for depression or anxiety)?

Yes (stop here)  No (complete screening)

1. During the **past month**, have you been hearing or seeing things that other people don't seem to hear or see?  Yes  No

2. During the **past month**, have you been bothered by feeling down, depressed, or hopeless?  Yes  No

3. During the **past month**, have you been bothered by little interest or pleasure in doing things?  Yes  No

If the client answered "yes" to any of the mental health screening questions a referral for further screening by a mental health professional is strongly encouraged.

Referral provided for Mental Health Treatment?  Yes  No  Client Refused

If yes, where: \_\_\_\_\_

Notes:

## Ryan White Part A Client Acuity Tool

Client Name:		Today's Date:		
<b><u>Barriers</u></b>	<b><u>Level 0-1</u></b> "0"-no intervention needed. "1"-short term, focused, education/support/referrals.	<b><u>Level 2</u></b> "2" multiple barriers, provide education/support.	<b><u>Level 3</u></b> "3"-Multiple, complicated barriers, and/or is in crisis.	<b><u>Level</u></b>
<b><i>Housing</i></b>	Stable, clean housing.	Requires short term assistance with/rent, utilities.	Homeless, shelter resident, or frequent moves.	
<b><i>Finances</i></b>	Steady, adequate source of income.	Income source is inconsistent or too low to meet basic needs.	Has no income. Is in financial crisis. Consistently unable to meet basic needs.	
<b><i>Transportation Issues</i></b>	Has own transportation to get to and from clinic visits.	Some difficulties with access to transportation.	Consistent problems with accessing transportation.	
<b><i>Social Support/Family Issues</i></b>	Dependable network/family/friends/partner.	Gaps in support system (family/friends periodically) Pregnant but adherent.	No stable support other than professionals. Family in crisis. Pregnant but not adherent. Fear of disclosure.	
<b><i>Behavior</i></b>	Functions appropriately in most settings.	Repeated incidences of inappropriate behavior.	Abuse or threats to others; lack of control.	
<b><i>Communication Issues</i></b>	Speak, read and understand English at an adult level.	Some difficulties with speaking, reading and understanding English.	Not able to represent themselves in English. Unable to read or write.	
<b><i>Cultural Issues</i></b>	Minimal system barriers	Requires some assistance acclimating to system.	Chooses not to/unable to acclimate to system.	
<b><i>System Issues</i></b>	Minimal system barriers.	Needs help accessing the system.	Distrust of system/not accessing services.	
<b><i>Legal Issues</i></b>	Client reports no recent or current legal problems; all pertinent legal documents completed.	Needs assistance completing standard legal documents; recent or current legal problems.	Involved in civil or criminal matters; incarcerated or recently incarcerated; undocumented immigrant; unaware of standard documents, i.e. living will.	
<b><i>Mental Health Issues</i></b>	No current mental health illness but has a history of mental illness, now stable.	Mild to moderate symptoms or disorders.	Severe symptoms/disorders; long history of mental disorders.	
<b><i>Substance Use/Abuse</i></b>	No current use and/or history.	History of abuse and/or intermittent abuse.	Chaotic life, regular substance abuse.	
<b><i>Side Effects</i></b>	On medication, having no side effects.	Minimal side effects affecting some quality of life.	Moderate to severe side effects affecting quality of life.	
<b><i>Adherence History</i></b>	Reports ability or willingness to adhere to medications.	Reports inconsistent ability to adhere to medications.	Reports inability to adhere to medications. Treatment naïve.	
<b><i>Educational Issues</i></b>	Has been informed, able to verbalize basic knowledge of the disease.	Some understanding of the disease.	No understanding of HIV disease. New diagnosis. <18 years of age.	
<b><i>Medical Needs</i></b>	Stable health; goes for periodic MD appointments and lab monitoring.	Needs primary care referral. Being seen by MD for short term illness.	Poor health; medical emergency; rapidly deteriorating; with opportunistic infections. Pregnant.	
<b><u>Comments Section:</u></b>				<b><u>Combined Total</u></b>
<b>Client Level Acuity Guidelines:</b>				
<b><u>Acuity Level</u></b>	<b><u>Range</u></b>	<b><u>Case Management Level</u></b>	<b><u>Referral Criteria</u></b>	
Life Area 0-1	15 Points or Less	Medical or Non-Medical Case Management	Self referral as needed	
Life Area 1 & 2	16-30 Points	Intensive Medical Case Management-Social	Refer to appropriate community partners	
Life Area 2 & 3	31 Points or Higher	Intensive Medical Case Management-Medical	Intensive Medical Case Manager to follow	
<p>Note: If a client scores a 3 in any life categories of Medical Needs, Educational Issues, or Adherence History, a referral to Intensive Medical Case Management is strongly encouraged. If a client scores a 3 in the life categories of Cultural Issues, Educational Issues, Social Support/Family Issues, Housing or Finances, a referral to Moderate Medical Case Management is strongly encouraged.</p>				

## Ryan White Part A Statement of Consumer Rights

The following statements reflect the rights and responsibilities of individuals with HIV-disease seeking Ryan White Part A funded care and support services within the Las Vegas Transitional Grant Area.

1. **RESPECT \* COURTESY \* PRIVACY**  
The consumer has the right to be treated, at all times, with respect and courtesy within a setting that provides the highest degree of privacy possible.
2. **FREEDOM FROM DISCRIMINATION**  
The consumer has the right to freedom from discrimination related to age, ethnicity, national origin, gender, disability, religion, sexual orientation, values and beliefs, marital status, medical condition, or any other arbitrary reasons.
3. **ACCESS TO HIV/AIDS SERVICE INFORMATION**  
The consumer has the right to full access to information from the healthcare providers about current FDA approved or other proven HIV/AIDS treatments. The consumer has the right to full access to information from all service providers about HIV-related social and support services.
4. **IDENTITY AND PROVIDER CREDENTIALS**  
The consumer has the right to know the identities, titles, and affiliations of all health and social service providers, as well as anyone else involved in the consumer's care.  
  
The consumer has the right to know about health or social service organizational rules and regulations that are pertinent to the care or type of care a client receives.
5. **CULTURALLY SENSITIVE SHARING OF INFORMATION**  
The consumer has the right to have information shared in a way that is easily understood and sensitive to each consumer's background, culture, and ethnicity.
6. **CONSENT AND CARE PLAN**  
The consumer has the right to be involved in and make decisions about their plan of care prior to the start of and during the course of treatment. Consumers have the right to renegotiate the care plan at any time.  
The consumer has the right to give informed consent before undergoing any healthcare procedure or receiving any social service. The consumer may change his or her mind after refusing or consenting to services without affecting ongoing care
7. **SELF DETERMINATION**  
The consumer has the right to access all available services pending eligibility.
8. **DECLINING SERVICES**  
The consumer has the right to refuse to participate in any care/service plan. Such refusal may affect eligibility. The consumer may change his or her mind regarding any service without affecting ongoing care.
9. **NAMING AN ADVOCATE**  
The consumer has the right to identify an advocate such as a family member or other person to support the consumer by notifying the relevant service provider.
10. **ADVANCE DIRECTIVES**  
The consumer has the right to have advance directives, such as a Living Will, Healthcare Proxy or Durable Power of Attorney for health and social services.
11. **ACCESS TO FINANCIAL INFORMATION**  
The consumer has the right to inspect and receive an explanation of healthcare bills or proposed changes, regardless of payment sources. The consumer has the right to receive needed referral and support with payment problems.
12. **CONSUMER GRIEVANCE PROCEDURE**  
The consumer has the right to file a written grievance without fear of pressure, retaliation, or interruption of services.  
The consumer has the right to receive a written response to a grievance in a timely manner.
13. **CONSUMER SATISFACTION**  
The consumer has the right to express his or her satisfaction or dissatisfaction with any Ryan White Part A Service Provider.
14. **CONFIDENTIALITY \* ACCESS TO RECORDS**  
The consumer has the right to confidentiality and access to treatment records and communications related to his or her case.
15. **OPEN DISCUSSION**  
The consumer has the right to open and honest discussion in all dealings with health or social service providers.
16. **CONTINUITY OF CARE AND TRANSFER**  
When a transfer for care/service for any reason is needed, the consumer shall be informed of all possible options.  
A provider may not initiate transfer of the consumer's case to another provider or facility unless a complete explanation of the need for the transfer and alternatives to transfer are provided to the consumer. The new provider or facility must be notified of the transfer.
17. **TERMINATION OF ELIGIBILITY**  
The consumer has the right to receive timely notification of program changes affecting eligibility.  
If deemed ineligible, the consumer has the right to pursue the Ryan White Part A eligibility appeals process.

I have received, reviewed, and understand the Statement of Consumer Rights:

_____	_____
<b>Printed Name of Client</b>	<b>Client URN#</b>
_____	_____
<b>Client's Signature</b>	<b>Date</b>
_____	_____
<b>(If Applicable) Parent or Guardian</b>	<b>Date</b>
_____	_____
<b>Care Coordinator</b>	<b>Date</b>

This client is judged unable to understand his/her consumer rights; therefore, I exercise the patient's rights.

_____	_____
<b>Care Coordinator or Parent/Guardian</b>	<b>Date</b>

## Ryan White Part A Grievance Procedure

The grievance procedure for Ryan White Client Care Services is as follows:

If your complaint is related to a problem you encountered while accessing services at one of the participating provider agencies, please bring your complaint/grievance to the attention of the appropriate person at that agency and follow the grievance procedure. Each agency has a grievance form available.

Upon your request you will be provided with:

- An agency grievance form in triplicate
- A pre-addressed and pre-stamped envelope addressed to the agency's executive director
- A pre-addressed and pre-stamped envelope addressed to the Las Vegas Part A Grants Administrator

After receipt of your written complaint/grievance, you will be contacted by the Ryan White Part A Grantee to discuss your concerns.

I have reviewed the above Grievance Procedure and have been offered a copy of the same:

Client's Signature	Date
Parent or Guardian	Date
Ryan White Part A Representative	Date



**Las Vegas Transitional Grant Area  
Ryan White Care Services**

**ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES  
RECONOCIMIENTO DE RECIBO DE LA NOTICIA DE  
PRACTICAS PRIVADAS**

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**I HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES:  
YO HE RECIBIDO UNA COPIA DE LA NOTICIA DE PRACTICAS PRIVADAS DE ESTA  
OFICINA:**

---

Please print name (Escriba su nombre, por favor)

---

Signature (firma)

---

Date (fecha)

---

**FOR OFFICE USE ONLY (PARA USO DE OFICINA SOLAMENTE)**

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A written acknowledgement of Receipt of our Notice of Privacy Practices was attempted; however acknowledgement could not be obtained because:

Individual refused to sign\_\_\_\_\_

Communication barriers prohibited obtaining the acknowledgement\_\_\_\_\_

An emergency situation prevented us from obtaining acknowledgement\_\_\_\_\_

Other: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Ryan White Part A Consent for Release of Confidential Information

Client's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ URN: \_\_\_\_\_

I, the undersigned, do hereby authorize any of the agencies listed below who participate in the community-based Ryan White Care Services program in the Las Vegas Transitional Grant Area (TGA) to release and/or share information concerning my eligibility, medical record status, and information concerning my HIV screening, diagnosis and treatment. The following agencies/programs authorized are:

- |                                     |   |
|-------------------------------------|---|
| ❖ Access to Healthcare              | ❖ Golden Rainbow                            |
| ❖ Aid for AIDS of Nevada (AFAN)     | ❖ Mohave County Health Department           |
| ❖ Community Counseling Center       | ❖ Nye County Health & Human Services        |
| ❖ Community Outreach Medical Center | ❖ Southern Nevada Health District           |
| ❖ Clark County Social Services      | ❖ University Medical Center-Wellness Center |
|                                     | ❖ Your Physician: _____                     |

Information may be released between the above listed agencies throughout the duration of my active enrollment in the Ryan White Care Services program. I may withdraw this consent by notifying, in writing, the Ryan White Part A agency where my eligibility was completed. I understand that my records are protected under federal HIPAA regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I may revoke this consent in writing any time, except to the extent that any action has been taken while it is still in force. This consent expires automatically one (1) year from registration or previously signed consent.

A copy of this authorization legally constitutes an original copy.

\_\_\_\_\_  
Client's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Guardian/ Relationship to Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

## Ryan White Part A Affected Client Consent for Release of Confidential Information

**Affected Client's Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **URN:** \_\_\_\_\_

I, the undersigned, do hereby authorize any of the agencies listed below who participate in the community-based Ryan White Care Services program in the Las Vegas Tgansitional Grant Area (TGA) to release and/or share information concerning my eligibility, medical record status, and information concerning my HIV screening, diagnosis and treatment. The following agencies/programs authorized are:

- |                                     |   |
|-------------------------------------|---|
| ❖ Access to Healthcare              | ❖ Golden Rainbow                            |
| ❖ Aid for AIDS of Nevada (AFAN)     | ❖ Mohave County Health Department           |
| ❖ Community Counseling Center       | ❖ Nye County Health & Human Services        |
| ❖ Community Outreach Medical Center | ❖ Southern Nevada Health District           |
| ❖ Clark County Social Services      | ❖ University Medical Center-Wellness Center |

Information may be released between the above listed agencies throughout the duration of my active enrollment in the Ryan White Care Services program. I may withdraw this consent by notifying, in writing, the Ryan White Part A agency where my eligibility was completed. I understand that my records are protected under federal HIPAA regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I may revoke this consent in writing any time, except to the extent that any action has been taken while it is still in force. This consent expires automatically one (1) year from registration or previously signed consent.

A copy of this authorization legally constitutes an original copy.

Affected Client's Signature (Required for persons over 18)	Date
Client Signature	Date
Parent or Guardian/ Relationship to Client	Date
Witness	Date

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I understand that, by signing this release, I am allowing \_\_\_\_\_ to seek  
Affected Client's Name  
 services and discuss issues concerning my service related information only, to assist in my  
 - \_\_\_\_\_-care. I also understand that I may revoke this consent in writing at any time.  
Client's Name

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I am withdrawing this consent for release of information.

Signature of Client	Date
Relationship	Date

## Ryan White Part A Homeless Declaration Form

Today's Date: \_\_\_\_\_

Client name: \_\_\_\_\_

Client URN: \_\_\_\_\_

I declare that I meet one of the following conditions of homelessness to fulfill the Ryan White Part A eligibility requirement for residency.

- Live in a motel, hotel or weekly rate housing
- Live in a shelter (family, domestic violence, youth shelter, or transitional living program).
- Live in an abandoned building, in a car, campground, or on the street
- Other: \_\_\_\_\_

Last known address:

\_\_\_\_\_

General area and zip code of where the client resides:

\_\_\_\_\_

I hereby declare that the above information regarding my current living situation is true.

\_\_\_\_\_  
Client's Signature

\_\_\_\_\_  
Date



**Ryan White Part A  
Verification of No Income**

I, \_\_\_\_\_, have requested services from Ryan White  
Client's Name  
Part A which requires verification of all income. I have stated during this  
verification that I have no income at this time.

I have not received income since \_\_\_\_\_.

I do not expect to receive income until \_\_\_\_\_.

I have applied for DDS or SSI on \_\_\_\_\_.

I understand that the above information is true and correct and understand that willfully giving false information will disqualify me from services and may result in legal/criminal action.

I further agree that if my financial status changes, I must immediately notify the Ryan White Part A eligibility agency and provide documentation of income.

\_\_\_\_\_  
Client's Signature Date

\_\_\_\_\_  
Parent or Guardian Date

\_\_\_\_\_  
Registering Agency Staff Member Date

\_\_\_\_\_  
Client Name Client URN#

**Verification of No Health Insurance Form**

**Client Section:**

Today's date: \_\_\_\_\_

I, \_\_\_\_\_,

Client Name

am currently employed full time or part time (please circle one)

at \_\_\_\_\_.

Name and Address of Employer

**Employer Section:**

I hereby declare that \_\_\_\_\_ is currently NOT eligible and  
WILL NOT

Client's Name

be eligible in the next six months to enroll in a private health insurance benefits  
plan

through their employer.

\_\_\_\_\_

Employer's name (please print)

\_\_\_\_\_

Phone number

\_\_\_\_\_

Employer's signature

\_\_\_\_\_

Date

Today's Date:     /     /		Client Name:	
Goal #1:			
<b>Case Manager's Tasks</b>	<b>Client's Tasks</b>	<b>Progress Note</b>	
Goal #2:			
<b>Case Manager's Tasks</b>	<b>Client's Tasks</b>	<b>Progress Note</b>	
Goal #3:			
<b>Case Manager's Tasks</b>	<b>Client's Tasks</b>	<b>Progress Note</b>	
<b>Conditions for Assistance:</b> Client will notify case management staff if there is ANY change in income or benefits and provide needed documentation. Client will also notify agency if there is a change in the number of persons in the household or a change in address or phone number.			
<b>Case Management Staff Contact Information:</b>			
Signing below indicates that you have read, understand and will comply with the case management care plan and terms above. This also indicates that you have received a copy of your case management care plan.			
Client's Signature:		Date:	
Case Manager's Signature:		Date:	

A copy of the completed (signed and dated) form must be given to the client in addition to a copy kept in the client chart.