

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.

Proof of Identification (Photo ID Required)	
	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: _____

Proof of Diagnosis (Required for newly registered clients only)	
	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

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

Proof of Income (Submit at least one dated within the last 90 days)	
	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: _____

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

Asset Verification	
	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 Reassessment 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 (more) <input type="checkbox"/> Returning Client (out of care for 12 months or more)		Assigned Case Manager:
DEMOGRAPHICS		
Last Name:	First Name:	Middle Name:
Date of Birth: / / (<input type="checkbox"/> check if estimated)	Age:	Social Security Number:
Home Address:		City:
State:	County:	Zip Code:
<input type="checkbox"/> check if same as home address Mailing Address:		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		
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

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:		
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)	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	

HOUSEHOLD AND INCOME INFORMATION

Have there been any household or income changes since you were last seen? (Household income includes spouses, domestic partners and any dependents that could be claimed on your taxes) Yes No

If yes, what are those changes?

CURRENT SERVICE NEEDS

What services are you in need of today, (please check all that apply):

<input type="checkbox"/> HIV/AIDS Medical Provider	<input type="checkbox"/> Nutrition Therapy	<input type="checkbox"/> Transportation Assistance
<input type="checkbox"/> HIV/AIDS Medication	<input type="checkbox"/> Housing Assistance	<input type="checkbox"/> Employment Assistance
<input type="checkbox"/> Assistance with Medication Co-Pays	<input type="checkbox"/> Emergency Financial Assistance	<input type="checkbox"/> Food Bank
<input type="checkbox"/> Substance Use Treatment/Counseling	<input type="checkbox"/> Support Groups	<input type="checkbox"/> HIV/AIDS Information
<input type="checkbox"/> Mental Health Treatment/Counseling	<input type="checkbox"/> Individual Counseling	<input type="checkbox"/> Vision Care
<input type="checkbox"/> Six month redetermination of eligibility for Ryan White services appointment	<input type="checkbox"/> Other:	

ADDITIONAL REFERRALS

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

Service Needed:	Organization Referred to:

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:		
Barriers	Level 0-1 "0"-no intervention needed. "1"-short term, focused, education/support/referrals.	Level 2 "2" multiple barriers, provide education/support.	Level 3 "3"-Multiple, complicated barriers, and/or is in crisis.	Level
Housing	Stable, clean housing.	Requires short term assistance with/rent, utilities.	Homeless, shelter resident, or frequent moves.	
Finances	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.	
Transportation Issues	Has own transportation to get to and from clinic visits.	Some difficulties with access to transportation.	Consistent problems with accessing transportation.	
Social Support/Family Issues	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.	
Behavior	Functions appropriately in most settings.	Repeated incidences of inappropriate behavior.	Abuse or threats to others; lack of control.	
Communication Issues	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.	
Cultural Issues	Minimal system barriers	Requires some assistance acclimating to system.	Chooses not to/unable to acclimate to system.	
System Issues	Minimal system barriers.	Needs help accessing the system.	Distrust of system/not accessing services.	
Legal Issues	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.	
Mental Health Issues	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.	
Substance Use/Abuse	No current use and/or history.	History of abuse and/or intermittent abuse.	Chaotic life, regular substance abuse.	
Side Effects	On medication, having no side effects.	Minimal side effects affecting some quality of life.	Moderate to severe side effects affecting quality of life.	
Adherence History	Reports ability or willingness to adhere to medications.	Reports inconsistent ability to adhere to medications.	Reports inability to adhere to medications. Treatment naïve.	
Educational Issues	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.	
Medical Needs	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.	
Comments Section:				Combined Total
Client Level Acuity Guidelines:				
Acuity Level	Range	Case Management Level	Referral Criteria	
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	
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.				

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:

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

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

_____	_____
Care Coordinator or Parent/Guardian	Date

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**

**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)

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 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 |
| | ❖ 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 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 |

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

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

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:			
Case Manager's Tasks	Client's Tasks		Progress Note
Goal #2:			
Case Manager's Tasks	Client's Tasks		Progress Note
Goal #3:			
Case Manager's Tasks	Client's Tasks		Progress Note
Conditions for Assistance: 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.			
Case Management Staff Contact Information:			
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.