



**ND RYAN WHITE PROGRAM PART B RECERTIFICATION**  
 NORTH DAKOTA DEPARTMENT OF HEALTH  
 DIVISION OF DISEASE CONTROL  
 SFN 59334 (02-2016)

**Complete this form and return to your ND Ryan White Part B Program Case Manager by October 31.**

Personal Information

Name	Date of Birth	ND Ryan White Client Number
Street Address		
City		
State/Zip Code		
Home Telephone	Email	Cell Phone

Employment

My income has changed since last reenrollment:  
 Yes  No If Yes, please attach proof of current income.

Medical Coverage

My medical coverage has changed since my last reenrollment:  Yes  No If Yes, please attaches a copy of your insurance card.

No Insurance  Traditional Medicaid  Medicaid Expansion  Private-Individual  Private-Employer  
 Medicare A/B  Medicare D  VA  IHS  Other (specify)\_\_\_\_\_

Medicaid Number	Medicare Part D Company and Policy Number
Health Insurance Company and Policy Number	Is your private coverage through the Marketplace? <input type="checkbox"/> Yes <input type="checkbox"/> No

1. Are you a tobacco user?  Yes  No  Former User  
 2. Are you interested in quitting at this time?  Yes  No  
 3. Are you exposed to second hand smoke?  Yes  No  
 4. Referral offered?  Yes  No

Client Signature	Date
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