ND RYAN WHITE PART B PROGRAM RECERTIFICATION
NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF SEXUALLY TRANSMITTED AND BLOODBORNE DISEASES
SFN 58583 (Rev. 07-2021)

Please complete this form and return to your Ryan White case manager by October 31 in order for Ryan White and ADAP services to continue after November 1st.

Client's Information

Name	Date of Birth	ND Ryan White Client Number		
Address		City	State	Zip Code
Mailing Address (if different)		City	State	Zip Code
Phone Number	Email			

Income and Housing Status

Has your income changed since reenrollment in April? ☐ No ☐ **Yes (please provide a month of pay stubs)**

Please select your housing type.
☐ Permanent housing (apartment, house, boarding house) ☐ Rent ☐ Own
☐ Temporary (transitional housing for homeless, staying with friends or family)
☐ Unstable (emergency shelter, jail, vehicle, streets, hotel or motel paid for by the emergency funding)

Health Coverage Information

Has your health coverage changed since April? ☐ No ☐ **Yes (please provide a copy of the card, front and back)**

Private Insurance	**Medicaid**	**Medicare**	**Other**	☐ **Marketplace Insurance paid by the Ryan White program**	☐ **I do not have health coverage since (date):**
☐ Employer based ☐ Private individual ☐ Dental ☐ Vision ☐ Other:	☐ Traditional ☐ Expansion ☐ Dually Eligible (Medicaid/Medicare)	☐ Part A/B ☐ Part D (drug coverage)	☐ VA ☐ IHS ☐ Other:	If selected, please complete the Health Coverage Screening and Attestation form.	

Insurance Provider's Name (e.g. BCBS)	Member ID	Policy Start Date
Insurance Provider's Name (e.g. BCBS)	Member ID	Policy Start Date

Client Signature	Date
Case Manager	Date