ND RYAN WHITE PROGRAM PART B CLIENT ENROLLMENT APPLICATION

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF DISEASE CONTROL
SFN 54191 (02-2020)

The following information is requested to determine if you qualify for the North Dakota Ryan White Part B Program.

All the information you provide is private and confidential. Only those people who need the information to do assist you will see your information. These people are the North Dakota Ryan White Program Part B staff; program auditors, your medical care providers, your pharmacist, your case manager, and any advocate you may list on this application. We will ask your permission for anyone else to see the information you give us.

Items you will need to provide:

☐ **Identity/Age**: Bring records that prove the identity and age of household member applying for assistance (birth certificate, driver's license, etc.).

☐ **Income**: Bring records to show your gross (before taxes) income for all household members (most recent tax form, wage stubs, SSDI, SSI, etc.).

☐ **Residence**: Bring records to show where you live (rent receipts, utility bills, etc.). You must be able to produce a state ID within 60 days of applying.

☐ **Health insurance**: Bring a copy of the insurance card (front and back). If uninsured and employed, must provide a proof that you are not eligible for employer sponsored insurance (completed Marketplace Employer Coverage Tool for all employed household members).

☐ **Medicaid/Medicare**: Bring a denial or acceptance letter if your income is below 138 percent of the Federal Poverty Level (FPL). Page 11 lists Medicaid income eligibility levels.

Answer the questions truthfully and to the best of your knowledge.

Return the completed form along with the required documentation to your case manager, or mail or fax to:

Ryan White Program Part B
North Dakota Department of Health
Division of Disease Control
2635 East Main Avenue
Bismarck, ND 58506-5520
Fax: 701.328.0338

For more information call the North Dakota Ryan White Program at 701.328.2378 or visit: www.ndhealth.gov/hiv.

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Case Management Site	ND Ryan White Client Number	ND ADAP Client Number

Applicant's Information

Name of Applicant		Social Security Number		
Street Address		City	State	ZIP Code
Mailing Address (if different)		City	State	ZIP Code
Primary Telephone Number	Secondary Telephone Number		Email Address	
Date of Birth	Country of Birth		Primary Language	

Gender
☐ Male ☐ Female ☐ Transgender M to F ☐ Transgender F to M ☐ Other:______________________

Risk Category (please select all that apply):
☐ Men having sex with men (MSM) ☐ Heterosexual contact ☐ Injection drug use (IDU)
☐ Hemophilia/coagulation disorder ☐ Perinatal (mother to child) ☐ Organ transplant or blood transfusion
☐ Work related exposure ☐ Unknown ☐ Other: _______________

Race (check all that apply)
☐ Asian ☐ American Indian ☐ Black/African American ☐ Pacific Islander ☐ White

Hispanic or Latino:
☐ Yes ☐ No

Physician's Name	Clinic	Pharmacy
Emergency Contact's Name	Phone Number	Relationship

Citizenship Status
☐ Citizen ☐ National ☐ Permanent Resident ☐ Temporary Visa ☐ Undocumented

Employment Status
☐ Employed full-time ☐ Employed part-time ☐ Self-employed Employer name: ________________
☐ Unemployed ☐ Student ☐ Disabled ☐ Retired ☐ Other: ____________________

Insurance Information (provide a copy of insurance card, front and back)

☐ **Private**	☐ **Medicare**	☐ **Medicaid**	☐ **Other**	☐ **No Insurance**
☐ Employer ☐ Individual policy ☐ Marketplace plan ☐ COBRA ☐ Dental	☐ Part A/B ☐ Part D ☐ Supplemental ☐ Low-Income Subsidy	☐ Traditional ☐ Expansion ☐ Dually Eligible (Medicaid/Medicare)	☐ VA ☐ IHS ☐ Other:	**Please complete the Statement of No Health Coverage (next section)**

Insurance Company Name:_______________ Member ID:____________________ Start Date: _________

Insurance Company Name:_______________ Member ID:____________________ Start Date: _________

Are you receiving assistance with insurance premiums through Ryan White? ☐ Yes ☐ No ☐ Not Sure

North Dakota Department of Health HIV·STD·TB VIRAL HEPATITIS PROGRAM
NORTH Dakota | Health Be Legendary.™

Statement of No Health Coverage (only complete if uninsured)

Please complete the following if you indicated that you currently have **no health** coverage.

☐ **My income for the past 12 months is below $17,609 (refer to table on page 11 for Medicaid eligibility levels).**

☐ I have applied for ND Medicaid in the past 6 months, but do not qualify due to my:

☐ Income ☐ Citizenship/immigration status ☐ Other: __________________

I have provided Medicaid denial letter to my case manager: ☐ Yes ☐ No

☐ I have not applied for ND Medicaid.

☐ **My income for the past 12 months is above $17,609.** I, or other member(s) of my household, are employed but:

☐ My employer does not offer health insurance.

☐ No one in my household is offered health insurance through employment in which I am an eligible party.

Complete the Marketplace Employer Coverage Tool for all employed household members.

☐ **During this six-month Ryan White eligibility period, there are no options for enrollment into health coverage through open/special periods**.

If you may be eligible for and have not obtained health insurance coverage through Medicaid, Medicare or Private Employer Based Plans, you are not in compliance with Ryan White Part B polices regarding "payer of last resort." This will render you ineligible for Ryan White Covered Services and you will be suspended from all services until appropriate coverage is obtained. Consideration will be made to provide medications and services for a **period of up to three months** to cover services until plans may become active. After that point, services will be unavailable.

If you have applied for and are not eligible for health insurance through Medicaid, Medicare or Private Employer Based Plans, you must enroll in a qualified health plan through the Health Insurance Marketplace with a Ryan White approved plan during the next enrollment period that you are eligible to apply under. The Ryan White program will pay your portion of the insurance premium and all co-pays and deductibles for outpatient medical services and medications related to HIV infection.

Failure to enroll in a health insurance plan during the next available enrollment period will result in a **one-year suspension** from the Ryan White Part B program or suspension until health insurance coverage is obtained.

________ (enter initials) I understand that Ryan White Part B program is a payer of last resort, not insurance, and can only cover services when there is no other payer. This means that if I am eligible for health coverage and I do not enroll, Ryan White will suspend my eligibility for Ryan White Part B for one-year or until I gain appropriate healthcare coverage.

For Case Managers:

☐ This client is in compliance with Ryan White Policies and qualifies for Ryan White services.

☐ This client is not in compliance with Ryan White Policies and should receive window period services covering the time period: ____.

☐ This client is not in compliance with Ryan White Policies and should not receive Ryan White services.

Client/Guardian Signature____ Date __________________

Case Manager Signature ____ Date __________________

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Household Characteristics

Housing Type (check one)
☐ Permanent housing (apartment, house, boarding house) ☐ Rent ☐ Own Cost/month: $________
☐ 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)

Are you receiving housing assistance (HOPWA, public housing, Section 8)?
☐ No ☐ Yes, please describe: ____

Describe current living arrangement (stability, safety, affordability).
____

Household Size and Income

Marital Status
☐ Single ☐ Married ☐ Civil Union ☐ Legally Separated ☐ Divorced ☐ Widowed ☐ Other:

List every family member who lives with you (legal spouse, biological/adopted/step-children) and anyone you claim as a dependent on your taxes. List their income if applicable. Attach additional sheets if needed.

Name	Relationship	Birth Date	Type of Income	Monthly Gross Income (before taxes)
	Self			

Household Size: | Total Monthly Household Gross Income:

Household Federal Poverty Level (to be completed by case manager; use page 11 to calculate):

Statement of No Income

If you currently have no income, please fill out the following information.
☐ I did not file income tax in 20_______. This statement is true to the best of my knowledge.
☐ I currently have no income and have not received income since ______________________
Please explain how your living expenses are met if you report no current income.
____
____

Ryan White Services Assessment

Please select which ND Ryan White services and service reimbursements you need:

- ☐ Case Management
- ☐ Outpatient HIV medical care
- ☐ Dental care
- ☐ Mental health
- ☐ Emergency Financial Assistance (rent and utilities)
- ☐ Medications (ADAP)
- ☐ Insurance premiums (ADAP)
- ☐ Vision care
- ☐ Substance abuse
- ☐ Transportation

Basic Needs Assessment

Please select areas where you need referrals and assistance:

- ☐ Housing/utilities
- ☐ Other chronic health conditions
- ☐ Food and clothing
- ☐ Paying bills/money management
- ☐ Other: ______________________________________
- ☐ HIV stigma and isolation
- ☐ Finding/keeping a job
- ☐ Citizenship/immigration status
- ☐ Language/cultural barriers
- ☐ Legal issues

Comments:

Retention in Care and HIV Risk Assessment

Have you seen your HIV provider in the last 12 months? ☐ Yes ☐ No Date of last visit:_______________	Comments:
How often you see your HIV provider? ☐ Every 3 months ☐ Every 6 months ☐ Once a year ☐ Other:	
Are you currently virally suppressed? ☐ Yes ☐ No ☐ I do not know	Is your CD4 count above 200 cells/mL? ☐ Yes ☐ No ☐ I do not know
List HIV medications you are currently taking.	Do you miss any doses, and if so, how often and reason:
Do you engage in risky sexual behaviors such as having multiple or anonymous sex partners or having unprotected sex? ☐ Yes ☐ No Comment:	

Recommended Screenings for Persons Living with HIV

Have you been screened for tuberculosis (TB) since HIV diagnosis? ☐ Yes, date tested:__________ ☐ No ☐ Latent TB ☐ Received treatment
Have you been screened for hepatitis B since HIV diagnosis? ☐ Yes, date tested:__________ Result: ___________________ ☐ No
Have you been screened for hepatitis C since HIV diagnosis? ☐ Yes, date tested:__________ ☐ No ☐ Have hepatitis C ☐ Previously treated ☐ Interested in treatment
Have you been screened for syphilis in the past 12 months? ☐ Yes, date tested:__________ Result: ___________________ ☐ No ☐ Not indicated (not sexually active)
Have you been screened for chlamydia and gonorrhea in the past 12 months? ☐ Yes, date tested:__________ Result: ___________________ ☐ No ☐ Not indicated (not sexually active)
Are you currently pregnant? ☐ Yes, estimated delivery date: ___________________________ ☐ No ☐ Not applicable

Substance Abuse and Mental Health

Are you a tobacco user? ☐ Yes ☐ No ☐ Former	Are you interested in quitting at this time? ☐ Yes ☐ No ☐ Not Applicable	Are you exposed to second-hand smoke? ☐ Yes ☐ No
Referral offered? ☐ Yes ☐ No ☐ Not Applicable	Comments:	
Do you currently use drugs or alcohol? ☐ Yes ☐ No ☐ Former	If yes, check all that apply: ☐ Alcohol ☐ Street drugs ☐ Injecting drugs ☐ Prescription drugs ☐ Other: ________________	
Would you like a referral? ☐ Substance Abuse Counseling ☐ Syringe Services ☐ Treatment programs ☐ Other: ________________ ☐ No ☐ Not applicable		
Referral offered? ☐ Yes ☐ No ☐ Not Applicable	Comments:	
Do you have mental health concerns? ☐ Yes ☐ No ☐ Former	Comments:	
Do you have a history of trauma in your life? ☐ Yes ☐ No	Do you have physical or emotional abuse concerns? ☐ Yes ☐ No	
Are you receiving counseling/treatment? ☐ Yes ☐ No ☐ Not Applicable	Are you interested in getting help? ☐ Yes ☐ No ☐ Not Applicable	
Referral offered? ☐ Yes ☐ No ☐ Not Applicable	Comments:	

To Be Completed by Case Manager – Acuity Scale

Life Area	0 points Self Mgmt.	1 point Basic Need	2 points Moderate Need	3 points High Need
Medical Case Management				
Linkage and Retention in Medical Care *Acuity Score:*	☐ Client attended all HIV medical appointments in the last 12 months.	☐ Client missed one appointment in the last 12 months or has rescheduled multiple appointments.	☐ Client missed more than one medical appointment in the last 12 months.	☐ No reported labs in the past 12 months. Client is: ☐ newly-diagnosed ☐ pregnant ☐ immuno-compromised. ☐ released from a correctional facility within the past 90 days. ☐ is/was hospitalized or used ER or urgent care in the last 30 days
Understanding of HIV and Risk Behavior *Acuity Score:*	☐ Understands risks and practices harm reduction behavior and communicates with sexual partners	☐ Understands risks and practices harm reduction most of the time.	☐ Has poor knowledge and engages in risky behaviors. Viral load	☐ Frequently engages in risky behaviors. Not virally suppressed. High risk for HIV

Life Area	0 points Self Mgmt.	1 point Basic Need	2 points Moderate Need	3 points High Need
	about safer sex (e.g. condom use, PrEP, testing)		detectable. Needs partner services.	transmission. Needs partner services.
Medication Adherence *Acuity Score:*	☐ Complete medication adherence reflected in the undetectable viral load.	☐ Misses doses occasionally with continued viral load suppression.	☐ Misses doses frequently. Has a detectable viral load below 200 copies/mL. Needs adherence counseling.	☐ Misses doses daily and has a viral load over 200 copies/mL. Needs adherence counseling.
Health Coverage *Acuity Score:*	☐ Has medical coverage. Able to access medical care.	☐ Enrolled in health coverage but requires support to maintain coverage.	☐ Has medical coverage but requires ADAP premium assistance and CM support to maintain coverage.	☐ No health coverage. ☐ Not eligible for public or private coverage. ☐ Eligible but not enrolled.
Non-Medical Case Management				
Basic Needs *Acuity Score:*	☐ Food, clothing, and other basic items available through client's own means. ☐ Has ongoing access to assistance programs that maintain basic needs consistently. ☐ Able to perform activities of daily living independently (ADL)	☐ Basic needs met on a regular basis with occasional need for help accessing assistance programs. ☐ Unable to routinely meet basic needs without emergency assistance. ☐ Needs assistance to perform some ADL weekly.	☐ Routinely needs help accessing assistance programs for basic needs. ☐ History of difficulties in accessing assistance programs on own. ☐ Often w/o food, clothing, or other basic needs. ☐ Needs in-home ADL assistance daily.	☐ Has no access to food. ☐ Without most basic needs. ☐ Unable to perform most ADL. ☐ No home to receive assistance with ADL.
Mental Health *Acuity Score:*	☐ No history of mental health problems. No need for referral.	☐ Past problems and/or reports current difficulties/stress – is functioning or already engaged in mental health care.	☐ Having trouble in day-to-day functioning. Requires significant support. Needs referral to mental health care.	☐ Danger to self or others and needs immediate intervention. Needs referral to mental health care.
Substance Use *Acuity Score:*	☐ No difficulties with substance use. No referrals needed.	☐ Past problems but currently in recovery. Not impacting ability to function daily or access medical care.	☐ Current substance use – willing to seek help. Impacts ability to function and access medical care.	☐ Current substance use – not willing to seek help. Unable to function daily or maintain medical care.
Housing *Acuity Score:*	☐ Living in clean, stable housing. Does not need assistance.	☐ Stable housing (subsidized or not). Occasionally needs	☐ Temporary housing (subsidized or not).	☐ Unstable housing.

Life Area	0 points Self Mgmt.	1 point Basic Need	2 points Moderate Need	3 points High Need
		housing assistance (<2 times per year).	Frequent violations and eviction notices and history of homelessness.	Currently facing eviction or homelessness.
Language and Cultural Barriers *Acuity Score:*	☐ No language/cultural barriers.	☐ Some language/cultural barriers that do not majorly affect access to medical care or services.	☐ Language & cultural barriers that prevent client from accessing medical care and services.	☐ Language/cultural barriers. Client is not able to access medical care or treatment without translation services and CM assistance.
Transportation *Acuity Score:*	☐ Has consistent and reliable access to transportation with no need for agency support.	☐ Occasionally needs transportation assistance to stay in medical care.	☐ Has a car or a bus pass but requires CM assistance in coordinating and reimbursing transportation.	☐ Limited or no access to transportation (language, cognitive ability, mental health) which impacts access to medical care and services.
Total Points:	**Add up the total points from each line to determine the total** 0 pts: Self-Management 1-10 pts: Basic Case Management 11-20 pts: Moderate Case Management 21-30 pts: Intensive Case Management			

Notes:
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ND Ryan White Program Part B Client Rights and Responsibilities

Client's Rights:
As a participant in the ND Ryan White Program Part B, you have the right to:

- Be treated with respect, dignity, consideration, and compassion.
- Receive case management services Be treated with respect, dignity, consideration, and compassion.
- Receive case management services free of discrimination on the basis of race, color, sex/gender, ethnicity, national origin, religion, age, class, sexual orientation, physical and/or mental ability.
- Participate in creating a plan for case management services.
- Be informed about services and options available to you.
- Reach an agreement with your case manager about the frequency of contact you will have, either in person or over the telephone.
- Have your medical records and case management records be treated confidentially.
- File a grievance about services you are receiving or denial of services

Client's Responsibilities:
As a participant in the North Dakota Ryan White Program Part B, you have the responsibility to:

- Treat other clients and staff of this agency with respect and courtesy.
- Protect the confidentiality of other clients you may encounter at this agency.
- Not subject case managers, staff, or other clients to physical, sexual, verbal and/or emotional abuse or threats.
- Participate as much as you are able in creating a plan for case management.
- Let your case manager know any concerns you have about your case management plan or changes in your needs.
- Make and keep appointments to the best of your ability, or if possible to phone to cancel or change an appointment time.
- Stay in communication with your case manager by informing him/her of changes in your address or phone number, income, and responding to the case manager's calls or letters to the best of your ability.
- Provide your case manager any requests for payment of bills within 30 days of the statement date and provide required documentation.
- Follow case manager directions to get assistance from other available programs and services.
- Stay in care by visiting your doctor regularly and take prescribed medication to ensure your health and well-being.
- Every six months recertify your eligibility and enrollment in the ND Ryan White Part B program. You **must reenroll by April 30th and recertify by October 31st** each year for continued Ryan White eligibility.

☐ I understand the above information, and I have received a copy for my records.

Client/Guardian Signature ____ Date ________________

Case Manager Signature ____ Date ________________

ND Ryan White Program Part B Client Release of Information

I, ________________________________, authorize ND Ryan White Program staff or their agents to discuss my case and diagnosis (if necessary) with the providers listed to obtain and maintain services that I may qualify for:

Case managers	Advocates
County financial worker	ND Medicaid representative
Physician	Clinic staff
Insurance enrollment assisters	Insurance providers
Other medical care providers (pharmacist, dentist, etc.)	Social worker

I also authorize ND Ryan White program to check with private insurers and employers about health or dental insurance I may have. This authorization is for the sole purpose of obtaining eligibility information dates and premium information in order to assist with insurance premiums and ensure appropriate health coverage.

This permission will expire one year from the date of my signature. I may revoke this authorization at any time by writing to the ND Ryan White program. If I revoke this authorization, ND Ryan White program staff and the persons indicated above may act on my information that has been released up to the date of that revoke.

I understand that information about me is protected by state and federal privacy laws. I understand that this information cannot be released without my consent, except as provided by law.

I understand that I do not have to sign this authorization form. If I choose not to sign this form, it may limit or curtail the services that may be offered to me. If I sign this form, I have the right to receive of a copy of the completed authorization.

Client/Guardian Signature ____ Date ________________

Case Manager Signature ____ Date ________________

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ND Ryan White Program Part B Certificate of Eligibility

The client's and case manager's signatures below certify that the eligibility criteria for ND Ryan White Program Part B have been met. The application includes all the supporting documents outlined below.

- ☐ **North Dakota Proof of Residency.** This includes rent receipts, utility or phone bills and within 60 days a state issued ID.
- ☐ **Proof of Income.** This includes most recent tax return, two weeks of paystubs, SSI/SSDI statement. Income eligibility criteria are met where annual income for the household is less than, or equal to, 400 percent of the Federal Poverty Level (FPL).

2019 HHS Poverty Guidelines

Size of Family Unit	100 Percent of Poverty	138 Percent of Poverty	400 Percent of Poverty
1	$12,760	$17,609	$51,040
2	$17,240	$23,791	$68,960
3	$21,720	$29,974	$86,880
4	$26,200	$36,156	$104,800

- ☐ **Proof of Health Coverage.** A copy of insurance policies (front and back) is attached. If client is uninsured, application for Statement of No Insurance is completed and appropriate documentation is provided.

- ☐ Client and case manager signed and provided a copy to the client:
  - ☐ Rights and Responsibilities
  - ☐ Release of Information
  - ☐ Certificate of Eligibility

Certification

I hereby certify that the representation of my income, insurance and other financial assistance is a true and accurate statement and that eligibility requirements as listed above have been met and documented.

I understand my Rights and Responsibilities, including completing eligibility documentation every 6 months, and reporting changes in income, insurance status, or residency to my case manager right away.

I understand that I must reenroll **each year by April 30 and recertify by October 31 for continued eligibility.** If I fail to do so, I will become ineligible to receive services through the ND Ryan White Program.

☐ I am interested in participating on the ND HIV Community Planning Group as a consumer-advisor about issues related to my status and care (optional).

Client/Guardian Signature ______________________________ Date ________________

Case Manager Signature ______________________________ Date ________________