Recertification Month: _____

ADAP ID: _____

Idaho Ryan White Medical Case Management

ANNUAL RECERTIFICATION

(PLEASE SELECT)

□ RWPB MCM □ IDAGAP

PERSONAL/CONTACT INFORMATION

Legal Last Name:	**Legal First Name:**	**MI:**

HAS YOUR ADDRESS OR PHONE NUMBER CHANGED IN THE PAST SIX MONTHS? □ **YES** □ **NO**

New Address:_____
(Street, unit number) (City, Zip Code)

New Phone Number: (____) _____-_____ □ Home □ Work □ Cell

HAS YOUR EMERGENCY CONTACT/LEGAL GUARDIAN CHANGED IN THE PAST SIX MONTHS? □ **YES** □ **NO**

New Contact:_____Phone (____) _____-_____ **Aware of HIV+ Status**: □ Yes □ No

Client Preference for Contact: □ phone □ phone message □ office visit □ home visit □ mail
□ email _____

May talk to: 1) _____ 2) _____

Are there any concerns related to the above contacts? If yes, please explain.

Relationship Status: □ Single □ Married □ Partner □ Divorced □ Separated □ Widow

Current Housing Status: □ Stable/Permanently Housed □ Institution □ Unstable □ Temporary

HIV STATUS

Since your last recertification, have you been diagnosed with AIDS? □ Yes □ No □ N/A
Date of diagnosis: _____/_____/_____

Medical Status:
Current CD4 count: _____ □ Self-Report □ Medical Records □ Estimated
Date of test: _____/_____/_____
Current Viral Load: _____ □ Self-Report □ Medical Records □ Estimated
Date of test: _____/_____/_____

Is client currently prescribed ARVs?
□ Yes □ No

INSURANCE INFORMATION

Primary Insurance Type (may mark more than one): □ No Insurance □ Private - Individual □ Private - Employer
□ Medicare Part A/B □ Medicare Part D □ Medicare (Part unspecified) □ Medicaid □ VA, Other Military □ IHS
□ Other (specify) _____ Please provide Medicare ID# _____

Additional Insurance Questions: Is insurance through the Health Insurance Exchange (ACA) □ Yes □ No

If you have insurance, what is the name of the of the insurance company and plan: _____

Does your health insurance cover medications? □ Yes □ No

If **Yes**, is there a total expense limit for medications? □ Yes □ No

If insurance is through previous employer, date COBRA Coverage began: _____/_____/_____

Have you applied for Medicaid? □ Yes □ No If **Yes**, Applied Date: _____/_____/_____

HIV Care Provider:

Name: _____ Phone: (____) _____-_____

Clinic Name: _____

Address: _____

Primary Care Provider:

Name: _____ Phone: (____) _____-_____

Clinic Name: _____

Address: _____

Primary Pharmacy:

Name: _____ Phone: (____) _____-_____

Address: _____

INCOME INFORMATION

Income is defined as any monies received on a periodic and/or predictable basis that is relied on to meet personal needs.			
Type of Income	**Please Select**	**Monthly Amount**	**Required Documentation**
Work	□ Yes □ No	$	2 months current, consecutive pay stubs
Self-Employment	□ Yes □ No	$	Last year's federal tax return, including Schedule C (if filed) AND previous 6 month's bank statements reflecting deposits (all accts)
Unemployment	□ Yes □ No	$	Stubs/Award Letter
Social Security Income (SSI)	□ Yes □ No	$	Current Year's Annual Award Letter
Social Security Disability Income (SSDI)	□ Yes □ No	$	Current Year's Annual Award Letter
Pension/Retirement	□ Yes □ No	$	Annual Benefit Statement
Short/Long Term Disability	□ Yes □ No	$	Benefit Award Letter
Veteran's Benefits	□ Yes □ No	$	Benefit Award Letter
Alimony/Child Support	□ Yes □ No	$	Benefit Award Letter OR other official document(s)
TAFI (Temporary Assistance for Families in Idaho)	□ Yes □ No	$	Most recent payment statement OR Benefit Award Letter
Stocks, bonds, cash dividends, trust, investment income, royalties	□ Yes □ No	$	Document(s) from financial institution showing income received, values, terms & conditions
Legal Spouse's Income	□ Yes □ No	$	See above for required document(s) by type of income
Other Income	□ Yes □ No	$	Depends on Source. Discuss with MCM

FINANCIAL OVERVIEW

Annual Gross Household Income: _____

Individual Annual Gross Income: _____

Household /Family Size: _____

NO INCOME STATEMENT

I, _____(Applicant Name), DO HEREBY DECLARE I AM NOT PRESENTLY RECEIVING ANY INCOME FROM ANY OF THE SOURCES LISTED ABOVE.

Applicant Signature: _____ Date_____/_____/_____

Falsifying and/or deliberately omitting information regarding your income (or household income) may result in immediate termination from the program and/or criminal charges and/or civil suit(s) to repay the amount of assistance received. This may also jeopardize continued grant funding of the Ryan White Part B/ADAP Program. By signing above, the applicant herby certifies that the information above is correct and true to the best of their knowledge.

Please Indicate Information has been Gathered and Shared by Having Client Initial the Appropriate Box	
Client Initials	**FORMS**
	Client Rights and Responsibilities
	Complaint Grievance Procedures
	Acknowledgement of Notice of Privacy Practices (agency specific)
For IDAGAP Clients ONLY – Applicant meets program requirements	
	Applicant does NOT qualify for Medicaid
	Applicant has Medicare Part A, or Part A and B, and Part D Coverage
CLIENT ACKNOWLEDGEMENT As a partner in this process, I acknowledge the following:	
	The information in this application is true to the best of my knowledge
	The purpose of my participation in Medical Case Management is to assure my engagement in HIV medical care
	I will notify my Medical Case Manager of any changes in my health insurance, financial, income or living arrangements
	I authorize this agency to share information and to coordinate care with the Ryan White Part B and Part C programs
	I understand that the financial assistance for the purchase of medications and services is subject to limits of the federal and state funding that is available for this program.
	This program involves the receipt of federal and/or state funds. Any person supplying false information is subject to state and/or federal criminal prosecution, which may result in fines, imprisonment or both. Additionally, there will be an automatic six-month suspension from RWPB programs and ADAP.

_____ _____

Client/Guardian Signature Date

_____ _____

Medical Case Manager Signature Date