

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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
New Address: _____ <small>(Street, unit number) (City, Zip Code)</small>		
New Phone Number: (____) ____ - ____ <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell		
HAS YOUR EMERGENCY CONTACT/LEGAL GUARDIAN CHANGED IN THE PAST SIX MONTHS? <input type="checkbox"/> Yes <input type="checkbox"/> No		
New Contact: _____ Phone (____) ____ - ____ Aware of HIV+ Status: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Client Preference for Contact: <input type="checkbox"/> phone <input type="checkbox"/> phone message <input type="checkbox"/> office visit <input type="checkbox"/> home visit <input type="checkbox"/> mail <input type="checkbox"/> email _____		
May talk to: _____		
Are there any concerns related to the above contacts? If yes, please explain.		
Relationship Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widow		
Current Housing Status: <input type="checkbox"/> Stable/Permanently Housed <input type="checkbox"/> Institution <input type="checkbox"/> Unstable <input type="checkbox"/> Temporary		

HIV STATUS

Since your last recertification, have you been diagnosed with AIDS? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Date of diagnosis: ____/____/____

INSURANCE INFORMATION

Primary Insurance Type (may mark more than one): <input type="checkbox"/> No Insurance <input type="checkbox"/> Private - Individual <input type="checkbox"/> Private - Employer <input type="checkbox"/> Medicare Part A/B <input type="checkbox"/> Medicare Part D <input type="checkbox"/> Medicare (Part unspecified) <input type="checkbox"/> Medicaid <input type="checkbox"/> VA, Other Military <input type="checkbox"/> IHS <input type="checkbox"/> Other (specify) _____ Please provide Medicare ID# _____
Additional Insurance Questions: Is insurance through the Health Insurance Exchange (ACA) <input type="checkbox"/> Yes <input type="checkbox"/> No
If you have insurance, what is the name of the of the insurance company and plan: _____
Does your health insurance cover medications? <input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes , is there a total expense limit for medications? <input type="checkbox"/> Yes <input type="checkbox"/> No
If insurance is through previous employer, date COBRA Coverage began: ____/____/____
Have you applied for Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes , Applied Date: ____/____/____
HIV Care Provider:
Name: _____ Phone: (____) ____ - ____
Clinic Name: _____

Primary Care Provider:	
Name: _____	Phone: (____) ____ - _____
Clinic Name: _____	
Primary Pharmacy:	
Name: _____	Phone: (____) ____ - _____

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	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	2 months current, consecutive pay stubs
Self-Employment	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	Last year's federal tax return, including Schedule C (if filed) AND previous 6 month's bank statements reflecting deposits (all accts)
Unemployment	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	Stubs/Award Letter
Social Security Income (SSI)	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	Current Year's Annual Award Letter
Social Security Disability Income (SSDI)	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	Current Year's Annual Award Letter
Pension/Retirement	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	Annual Benefit Statement
Short/Long Term Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	Benefit Award Letter
Veteran's Benefits	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	Benefit Award Letter
Alimony/Child Support	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	Benefit Award Letter OR other official document(s)
TAFI (Temporary Assistance for Families in Idaho)	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	Most recent payment statement OR Benefit Award Letter
Stocks, bonds, cash dividends, trust, investment income, royalties	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	Document(s) from financial institution showing income received, values, terms & conditions
Legal Spouse's Income	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	See above for required document(s) by type of income
Other Income	<input type="checkbox"/> Yes <input type="checkbox"/> 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 hereby 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