

INSURANCE INFORMATION

Do you have private health insurance? Yes No
If **yes**, is your health insurance through your current or previous employer? Yes No
If through previous employer, date COBRA Coverage began: ____/____/____
If **yes**, does your health insurance cover medications? Yes No
If **yes**, is there a total expense limit for medications? Yes No

Patient Insurance Information:
 Patient Guarantor (Name: _____) Birth Date of Insured: ____/____/____
Address (if different from above) City & State, Zip Code: _____

Home Phone: (____) _____ - _____ Work Phone (if applicable): (____) _____ - _____

Name of Primary Insurance: Uninsured Blue Cross Blue Shield Idaho Physicians Network
 Medicaid Medicare Tricare VA/CHAMPUS Applied for Medicaid (Date: ____/____/____)
 Other (specify) _____

FINANCE INFORMATION

Annual Gross Household Income: _____ Individual Annual Gross Income: _____ Household/ Family Size: _____	<i>(For state office use only)</i>
	_____ Percent Poverty Level <input type="checkbox"/> Copy of Income Documentation <input type="checkbox"/> Copy of Photo Identification <input type="checkbox"/> Copy of Insurance Card (front and back)

HOUSING STATUS

Most Recent/Current Housing Status: Stable/ Permanently Housed Non-permanently Housed Institution
 Unstable Other (specify) _____ Unknown/Unreported

Client Acknowledgement:

As a partner in this process, I acknowledge that:

- 1) The above information is true to the best of my knowledge (____).
- 2) The purpose of my participation in medical case management is to assure my engagement in HIV medical care (____).
- 3) I will notify my medical case manager of any change in my health insurance status, financial situation, income, or living arrangements (____).
- 4) I authorize this agency to share information and to coordinate care with the Ryan White Part B and Part C programs (____).
- 5) 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

Date