

Date of Intake:

ADAP ID:

Idaho Ryan White Medical Case Management INTAKE AND ELIGIBILITY DETERMINATION

(PLEASE SELECT)

- RWPB NEW Intake
 IDAGAP NEW Intake
 Re-Enrollment

PERSONAL/CONTACT INFORMATION

Legal Last Name:		Legal First Name:		MI:
Preferred Name:				
Date of Birth: ____/____/____		Social Security Number (Required for IDAGAP ONLY): _____		
Gender Assigned at birth: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Refuse to Report Current Gender Identity: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender, Male to Female <input type="checkbox"/> Transgender, Female to Male <input type="checkbox"/> Refuse to Report				
Address:		City:		
County:		State: IDAHO		Zip Code:
Mailing address if different from above:				
Phone: H (____) ____ - ____ W (____) ____ - ____ Cell/Pager (____) ____ - ____				
Emergency Contact/ Legal Guardian: _____ 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: 1) _____ 2) _____				
Are there any concerns related to the above contact(s)? 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				
Preferred Language: _____			Interpreter Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Current Housing Status: <input type="checkbox"/> Stable/Permanently Housed <input type="checkbox"/> Institution <input type="checkbox"/> Unstable <input type="checkbox"/> Temporary				

Race (may mark more than one): <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander	Hispanic Subgroup: (ONLY select if Hispanic Ethnicity was marked) <input type="checkbox"/> Mexican, Mexican American, Chicano/a <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Another Hispanic, Latino/a or Spanish origin
	Asian Subgroup: (ONLY select if Asian was marked) <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian
Ethnicity <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Hispanic	Native Hawaiian or Other Pacific Islander Subgroup: (ONLY select if Native Hawaiian or Other Pacific Islander was marked) <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander

HIV STATUS

Proof of HIV Diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Original HIV Diagnosis <input type="checkbox"/> Self-Report <input type="checkbox"/> Medical Records ____/____/____ <input type="checkbox"/> Estimated State where diagnosed _____ Original CD4 count _____		
AIDS Diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Original HIV Diagnosis <input type="checkbox"/> Self-Report <input type="checkbox"/> Medical Records ____/____/____ <input type="checkbox"/> Estimated Year first accessed care _____ Original CD4 count at AIDS diagnosis _____		
HIV Status: <input type="checkbox"/> HIV Positive (not AIDS) <input type="checkbox"/> HIV Negative (affected) <input type="checkbox"/> HIV Positive (AIDS status unknown) <input type="checkbox"/> HIV Indeterminate (0-2 years) <input type="checkbox"/> CDC-Defined AIDS <input type="checkbox"/> Unknown		Is client currently prescribed ARVs? <input type="checkbox"/> Yes <input type="checkbox"/> No
Risk Factor (check all that apply): <input type="checkbox"/> MSM <input type="checkbox"/> IDU <input type="checkbox"/> Hemophilia/Coagulation Disorder <input type="checkbox"/> Heterosexual Contact <input type="checkbox"/> Receipt of transfusion blood, blood components or tissue <input type="checkbox"/> Mother with/at Risk for HIV <input type="checkbox"/> Not Reported or Not Identified		
Initial Idaho Ryan White Lab: Current CD4 count: _____ Date of test: ____/____/____ Current Viral Load: _____ Date of test: ____/____/____		
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	<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: _____
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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.

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: _____/_____/_____

**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
	What you Need to Know about Idaho Laws on HIV
	Acknowledgement of Notice of Privacy Practices (agency specific)
For IDAGAP Clients ONLY – Applicant meets program requirements	
	Applicant’s income is between 151% - 200% of FPL
	Applicant does NOT qualify for Medicaid
	Applicant has Medicare Part A, or Part A and B, and Part D Coverage
	Applicant does NOT qualify for Low Income Subsidies
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
	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

MCM - Please Select

Client Qualifies for: **RWPB** Medical Case Management **RWPC** Medical Case Management ADAP IDAGAP