Application Month:

_____

Idaho Ryan White Medical Case Management
ANNUAL RECERTIFICATION

PERSONAL/CONTACT INFORMATION

Legal Last Name:	**Legal First Name:**	**MI:**
Address:		**City:**
County:	**State:**	**Zip Code:**
Mailing address if different from above:	**Social Security Number:**	

Phone (H) (____) _____-_____ **(W)** (____) _____-_____ **Cell/Pager** (____) _____-_____

Emergency Contact/ Legal Guardian: _____ **Phone** (____) _____-_____
Aware of HIV+ Status: □ **Y** □ **N**

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.

Preferred Language: _____ **Interpreter Needed?** □ Yes □ No

HIV STATUS

Since your last recertification, have you been diagnosed with AIDS? □ Yes □ No □ NA
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

HIV Care Provider:
Name: _____ Phone: (____) _____-_____
Clinic Name: _____
Address: _____

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

Primary Pharmacy:
Name: _____ Phone: (____) _____-_____

Address: _____

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) _____

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 Y**es**, 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: ____/____/_____

FINANCE INFORMATION

Annual Gross Household Income: _____ **Individual Annual Gross Income:** _____ **Household/ Family Size: _____**	*(For state office use only)* _____ Percent Poverty Level □ Copy of Income Documentation □ Copy of Photo Identification □ Copy of Insurance Card (front and back)

HOUSING STATUS

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

Please indicate information has been gathered and shared by having client initial the appropriate box.	
Informational Forms (client provided copies and time for questions & answers):	***Client's Initials***
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)	
Other:	

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 Signature Date