

This form is to ONLY be used when enrolling clients NEW to the MCHPD Ryan White Services Program or Re-Entering into the program after being inactive for 2 years or more.

Marion County Public
Health Department
Ryan White HIV
Services Program
Membership
Application





Prevent. Promote. Protect.

Marion County Public Health Department Ryan White HIV Services Program Enrollment Application

Table with 3 columns: Name (First, MI, Last), Date of Birth, MCPHD RWSP ID#

Thank you for assisting your client's with the Marion County Public Health Department Ryan White HIV Services Program new/re-entry enrollment application. Please check all boxes that apply to client. If all boxes are checked the application is complete and ready for submission. Please fax all necessary enrollment application and required documents to your agency's MCPHD RWSP Business Coordinator for entry into the MCPHD RWSP RISE database.

- 1. [] Completed MCPHD Ryan White Services Program enrollment application
2. [] Attach proof of HIV status
3. [] Attach proof of Income (income taxes for the previous year only if self-employed)
4. [] Attach copies of other insurance cards.
5. [] Attach "No Tax Form" if the client did not file income taxes for the previous year (only if self-employed)
6. [] Attach proof of Indianapolis TGA residency
7. [] Attach copy of state issued ID with current address
8. [] Attach letter from assigned Medical or Non-Medical Case Manager if the client's ID does not match the stated address on enrollment application.
9. [] Attach employer verification form filled out by client's employer verifying client's is and/or is not eligible to receive benefits through their place of employment (if applicable).
10. [] Attach one current Medicaid Insurance verification.

The Marion County Public Health Department; Ryan White HIV Services Program is designed to assist HIV positive clients who reside in the following counties: Boone, Brown, Hancock, Hamilton, Hendricks, Johnson, Marion, Morgan, Putnam and Shelby counties

Questions or concerns can be directed to your agency business coordinator:

Alisha Hooks: ahooks@marionhealth.org or (317) 221-4623

Lisa Robinson: lrobinson@marionhealth.org or (317) 221-3552

Tashawna Summers: tsummers@marionhealth.org or (317) 221-3553

Signature of non-medical/medical case manager Location Date

I certify that all information is accurate and attached for the processing of this application.



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Marion County Public Health Department
Ryan White HIV Services Program Enrollment Application

NEW ENROLLMENT

RE-ENTRY

RWSP ID #

Application Effective Date
(First date ever enrolled into program or 2 or more years from last expiration date)

Attestation Due Date
(6 MONTHS FROM THE DATE OF ENROLLMENT)

APPLICANT INFORMATION

First Name:

M.I.:

Last Name:

Preferred First Name:

M.I.:

Preferred Last Name:

Date of birth (as stated on state ID):

Social Security Number:

Phone number:

Gender: Male Female Transgender
Male to Female Female to Male

Sex at Birth: Male Female

Current address:

City: State: ZIP Code: County:

How long have you lived there? Can mail be received?: Yes No

Mailing address, if different than above: Can mail be received?: Yes No

City: State: Zip Code: County:

Housing Status
Stable Permanent Temporary Housing Unstable Housing

PROGRAM and STATUS INFORMATION

HIV Care Facility:
IU Health Methodist - Life Care
Eskenazi Health-IDC
Community Infectious Disease
Damien Cares
Non-Ryan White funded Physician (Private Provider, ex. Inf. Dis. of Ind.):

HIV Care Provider:

Primary Case Management/Care Coordination site:
Concord Center Eskenazi Health-IDC
The Damien Center IU Health Methodist-LifeCare
Non Ryan White funded case management site: Step-Up

FIRST & LAST NAME OF PRIMARY CARE COORDINATOR/CASE MANAGER:

HIV STATUS

HIV Status:
HIV positive (Not AIDS) HIV positive (AIDS status unknown)

HIV Diagnosis Date

HIV Verification Source

HIV Verification Date:
(Date on confirmed HIV positive test result)

AIDS Status (if applicable):
CDC-defined AIDS

AIDS Diagnosis Date (if applicable):

APPLICANT INFORMATION

Name (First, M.I., Last):

RWSP ID#:

RACE/ETHNICITY

RACE (Please check the best one that applies)	Ethnicity	If selecting a Hispanic Ethnicity, select a Hispanic subgroup below	If selecting Asian as a race, select an Asian Subgroup below	If selecting Native Hawaiian or Pacific Islander as a race, select a Native Hawaiian or Pacific Islander subgroup below
<input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Native Alaskan <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Bi-Racial <input type="checkbox"/> Other <input type="checkbox"/> Unknown or Not reported <input type="checkbox"/> African	<input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic, Latino or Spanish	<input type="checkbox"/> Mexican, Mexican American or Chicano/a <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Other Hispanic, Latino or Spanish <input type="checkbox"/> Bi-Racial <input type="checkbox"/> Unknown or Not reported	<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	<input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Bi-Racial <input type="checkbox"/> Unknown or Not reported

EMPLOYMENT

Current Employer:

How long employed:

Hourly Salary **(Please circle)**

Monthly Income:

Indicate type of proof of Income:

Pay amount:

Verification date:

% of poverty:

Calculate income amount here:

MEDICAL INSURANCE				RWSP ID#:
Tier One (Full Coverage)				
Coverage (Yes/No)	Type of Medical Insurance	Applied Date (Month/Day/Year)	Effective Start Date (Month/Day/Year)	Effective End Date (Month/Day/Year)
	MCHD Ryan White HIV Services Program Only (no other coverage)			
	Eskenazi Health Advantage			
	Emergency Medicaid			
	Medicare Part A Only (Hospital coverage)			
Tier Two (Limited Coverage)				
Coverage (Yes/No)	Type of Medical Insurance	Applied Date (Month/Day/Year)	Effective Start Date (Month/Day/Year)	Effective End Date (Month/Day/Year)
	Medicare A & B			
	MDAP (Medicare Drug Assistance Program – administered by ISDH)			
	Medicare Part D			
	Medicaid QMB Only (covers co-insurance and deductibles for individuals with Medicare)			
	ADAP & EIP (Early Intervention Program – administered by ISDH)			
	Delta Dental (administered by ISDH)			
	Veterans			
Tier Three (Wrap Around Coverage)				
Coverage (Yes/No)	Type of Medical Insurance	Applied Date (Month/Day/Year)	Effective Start Date (Month/Day/Year)	Effective End Date (Month/Day/Year)
	Traditional Medicaid (Package A)			
	Medicaid QMB Also			
	Medicare Part C			
	Private Insurance – (Employer Paid)			
	Private ACA coverage paid for outside of ISDH (premium paid for by client's)			
	Anthem – Silver Pathway (ACA coverage) (ISDH covered plan)			
	IU Health Plans – Silver Copay (ACA coverage) (ISDH covered plan)			
	MDWise Marketplace Silver Plus (ACA coverage) (ISDH covered plan)			

APPLICANT INFORMATION

Name (First, M.I., Last):

RWSP ID#:

MEDICAL INSURANCE

Tier Three (Wrap Around Coverage - continued)

Coverage (Yes/No)	Type of Medical Insurance	Applied Date (Month/Day/Year)	Effective Start Date (Month/Day/Year)	Effective End Date (Month/Day/Year)
	Ambetter from MHS-Ambetter Secure Care 1 (2017) (ACA coverage) (ISDH covered plan)			
	CareSource Indiana, Inc. - Silver (ACA coverage) (ISDH covered plan)			
	COBRA (Employer offered)			
	Hoosier Health Wise			
	Hoosier Care Connect Anthem / MDWise / MHS/CareSource (Circle carrier)			
	HIP 2.0 Adult Hospital Presumptive Eligibility Anthem / MDWise / MHS/CareSource (Circle carrier)			
	HIP 2.0 State Plan Basic Anthem / MDWise / MHS/CareSource (Circle carrier)			
	HIP 2.0 State Plan Plus Anthem / MDWise / MHS/CareSource (Circle carrier)			
	HIP Basic Anthem / MDWise / MHS/CareSource (Circle carrier)			
	HIP Plus Anthem / MDWise / MHS/CareSource (Circle carrier)			

OTHER MEDICAL INSURANCE INFORMATION

	Not eligible for employer insurance until open enrollment			
	Client denied insurance prior to knowledge of status			

APPLICANT INFORMATION	
Name (First, M.I., Last):	RWSP ID#:
CONTACT INFORMATION	

Contact Numbers	Ok to leave message?
Primary: ()	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Alternate: ()	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Message: ()	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Email:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

EMERGENCY CONTACT					
First Name	Last Name	Relationship	Phone number	Ok to leave message	Aware of HIV status?
				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

Applicant Information (Continued)		
HIV RISK INFORMATION (HIV EXPOSURE)		
(Please check appropriate HIV exposure category for client – <u>Only One</u>)		
<input type="checkbox"/> Sex with Men (MSM)	<input type="checkbox"/> Sex with men and IDU (MSM/IDU)	<input type="checkbox"/> Injection Drug Use
<input type="checkbox"/> Heterosexual Contact	<input type="checkbox"/> Hemophilia or Coagulation Disorder	<input type="checkbox"/> Mother with or at risk for HIV (Perinatal)
<input type="checkbox"/> Other Risk, Not reported, unidentified	<input type="checkbox"/> Blood transfusion/components/tissue	<input type="checkbox"/> Health Care exposure

APPLICANT INFORMATION

Name (First, M.I., Last):	RWSP ID#:
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CERTIFICATION OF COMPLIANCE

CLIENT AGREEMENT

Please read the statements below and initial by each statement. Please sign & date in the space provided to certify your understanding and agreement as a Marion County Public Health Department Ryan White HIV Services Program client.

1. _____ I understand that the information requested on this application is for the purpose of determining my eligibility for a
Client's Initials federally funded program.
2. _____ I understand that the funding is limited and may expire at any time without extended or alternate program funding
Client's Initials being made available.
3. _____ I understand that this is not an entitlement program and any unruly behavior could jeopardize my enrollment into the
Client's Initials program.
4. _____ I understand that this is a program to assist clients with services until a more comprehensive insurance is obtained and
Client's Initials **not an insurance** that will balance a bill to zero out a claim
5. _____ I understand that I **must** report all changes, which may affect my eligibility for this program, such as income, insurance
Client's Initials coverage or change of residence. Changes will be evaluated to determine if continued eligibility will be approved and I will be notified in writing from my Care Coordinator if I will be terminated from this program.
6. _____ I understand that should I submit false information regarding any eligibility determining information, I may be subject
Client's Initials to repaying all costs for services provided during that time.
7. _____ I understand that I must re-certify my application bi-annually (every 6 months) in order to continue receiving services
Client's Initials funded by the MCPHD Ryan White HIV Services program.
8. _____ I have been given the information for the Ryan White Planning Council and have an understanding of what the council
Client's Initials represents and what roll I would play as a consumer on the council if accepted.
9. _____ I understand that if I opt out of my employer's insurance before learning of my status, I must enroll in my employer's
Client's Initials insurance at the first open enrollment opportunity or forfeit eligibility for all Ryan White HIV Services Programs that would be eligible to be covered under the Private Insurance, which includes Medical, Dental and Vision services.
10. _____ I understand that Ryan White funds are to remain payer of last resort. Should I have access to Private Health Insurance
Client's Initials and opt not to take such insurance I am not eligible for services through the Ryan White HIV Services Program that would be eligible to be covered under the Private Insurance. This includes Medical, Dental, and Vision services.

Care Coordinator/Non-Medical; Medical Case Manager Agreement

11. _____ I understand as the Care Coordinator/Non-Medical or Medical Case Manager of the client's listed above
CC initials that all documentation is true and accurate. If the eligibility documents submitted are found to be falsified in anyway the funded agency runs the risk of paying back all services provided to the client as well as losing funding for the indicated service the next grant year.

Signatures:

I certify that the information provided on this form is true and accurate.

Signature of applicant:	Date:
Signature of Care Coordinator:	Date:
Signature of Designated Agency Application Approver:	Date:
Approval of Ryan White HIV Services Program	