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

MARION COUNTY PUBLIC HEALTH DEPARTMENT

Prevent. Promote. Protect.

MARION COUNTY PUBLIC HEALTH DEPARTMENT

Prevent. Promote. Protect.

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

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: achooks@marionhealth.org or (317) 221-4623

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

Tashawnna 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.

MARION COUNTY PUBLIC HEALTH DEPARTMENT

Prevent. Promote. Protect.

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
☐ The Damien Center
☐ Non Ryan White funded case management site: _____
☐ Eskenazi Health-IDC
☐ IU Health Methodist-LifeCare
☐ 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**
☐ White ☐ Black/African American ☐ Asian ☐ American Indian or Native Alaskan ☐ Native Hawaiian or other Pacific Islander ☐ Bi-Racial ☐ Other ☐ Unknown or Not reported ☐ African	☐ Hispanic ☐ Not Hispanic, Latino or Spanish	☐ Mexican, Mexican American or Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other Hispanic, Latino or Spanish ☐ Bi-Racial ☐ Unknown or Not reported	☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian	☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ Bi-Racial ☐ 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: ( )	☐ Yes ☐ No ☐ Unknown
Alternate: ( )	☐ Yes ☐ No ☐ Unknown
Message: ( )	☐ Yes ☐ No ☐ Unknown
Email:	☐ Yes ☐ No ☐ Unknown

EMERGENCY CONTACT					
First Name	**Last Name**	**Relationship**	**Phone number**	**Ok to leave message**	**Aware of HIV status?**
				☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown

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

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

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. _____ *Client's Initials* I understand that the information requested on this application is for the purpose of determining my eligibility for a federally funded program.
2. _____ *Client's Initials* I understand that the funding is limited and may expire at any time without extended or alternate program funding being made available.
3. _____ *Client's Initials* I understand that this is not an entitlement program and any unruly behavior could jeopardize my enrollment into the program.
4. _____ *Client's Initials* I understand that this is a program to assist clients with services until a more comprehensive insurance is obtained and **not an insurance** that will balance a bill to zero out a claim
5. _____ *Client's Initials* I understand that I **must** report all changes, which may affect my eligibility for this program, such as income, insurance 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. _____ *Client's Initials* I understand that should I submit false information regarding any eligibility determining information, I may be subject to repaying all costs for services provided during that time.
7. _____ *Client's Initials* I understand that I must re-certify my application bi-annually (every 6 months) in order to continue receiving services funded by the MCPHD Ryan White HIV Services program.
8. _____ *Client's Initials* I have been given the information for the Ryan White Planning Council and have an understanding of what the council represents and what roll I would play as a consumer on the council if accepted.
9. _____ *Client's Initials* I understand that if I opt out of my employer's insurance before learning of my status, I must enroll in my employer's 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. _____ *Client's Initials* I understand that Ryan White funds are to remain payer of last resort. Should I have access to Private Health Insurance 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. _____ *CC initials* I understand as the Care Coordinator/Non-Medical or Medical Case Manager of the client's listed above 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	