MARION COUNTY PUBLIC HEALTH RYAN WHITE HIV SERVICES PROGRAM NOTICE OF CHANGE FORM

This form is to be used if there are any changes in eligibility requirements such as residency, insurance, income or death. This form is also to be used if there has been a change in name, gender, HIV status, care coordination or primary medical site. Any updates or corrections in social security number or date of birth are also to be submitted on this form to the Ryan White HIV Services Program.

Marion County Public Health Ryan White HIV Services Program
Notification of Change

APPLICANT INFORMATION	RWSP ID #

The client listed below has had the following change in one or more areas such as name, gender, obtained a social security number or submitting an update on a previously submitted social security number or submitting correction on a previously submitted date of birth.

Has Ryan White HIV Services Program CAREWare Data Manager been notified of name change? ☐ Yes ☐ No

First Name:	M.I:	Last Name:
New First Name:	**M.I:**	**New Last Name:**
Date of birth (as stated on state ID): ___ ___ /___ ___ /___ ___ ___ ___	**Social Security Number:**	

Gender Information

Has Ryan White HIV Services Program CAREWare Data Manager been notified of gender change? ☐ Yes ☐ No

Gender: ☐ Male ☐ Female	☐ Transgender ☐ Male to Female ☐ Female to Male	Sex at Birth: ☐ Male ☐ Female

HIV Status

The above client has had a change in HIV Status:

☐ **No**

☐ **Yes: AIDS Conversion Date: _____/_____/_____ State of Conversion if not Indiana: _____**

****If yes, please change in CAREWare Demographics tab**

Residency

Has Ryan White HIV Services Program CAREWare Data Manager been notified of residency change? ☐ Yes ☐ No

The above client has established new residence outside of the Indianapolis Transitional Grant Area (TGA) (Boone, Brown, Hamilton, Hancock, Hendricks, Johnson, Marion, Morgan, Putnam and Shelby counties).

I understand that if the above client moves outside the Indianapolis TGA, the client will no longer be eligible to receive coverage through the MCPHD RWSP beginning the first day the client leaves the Indianapolis TGA. It is at that point the client's status in the MCPHD RWSP becomes "**INACTIVE**."

☐ **Yes, Date Client moved outside TGA.** ___ ___ /___ ___ /___ ___ ___ ___
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☐ **No, still lives within the TGA just changed address from most recently submitted application**
If changes have occurred, please attach proof of TGA residency within the past 6 months. (i.e. an utility bill, lease agreement, cell phone bill, or an EOB. Verification must be in client's name)

Street Address	City	State	Zip	County

INCOME STATUS

The above client has had the following change in income:

☐ **Income status has changed since most recent enrollment application, recertification or attestation.**
If changes have occurred, please attach most recent proof of income within the past 30 days.

Proof of income attached	Client monthly gross income	Relationship to client	Verification Date

Total income here

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APPLICANT INFORMATION	PAGE 2
Name (First, M.I., Last):	**RWSP ID#:**

INSURANCE

****Please submit supporting documentation (i.e. enrollment letter with beginning date or termination letter with ending date)****

Has this change been documented in CAREWare? ☐ Yes ☐ No

The above client has had the following change in health coverage:

☐ Client's health coverage has changed since most recent enrollment application, recertification or attestation.

If changes in medical coverage have occurred, please indicate the effective and expiration dates of previous coverage as well as new coverage in the spaces below. Also attach copies of documentation or copies of new insurance cards

Medical Coverage	Applied Date	Effective (Beginning) Date	Coverage Termination Date

Date of Death

Has this change been documented in CAREWare?

☐ Yes ☐ No

****Please change enrollment status to "Referred" or "Discharged" and change Vital status to "Deceased" and enter Date of Death into the field in CAREWare and close the case.**

On ____/____/____, the Care Coordinator at the Care Coordination site listed above was informed that the client listed above has
Date
passed away.

Date of death of client: ____/____/____

- I certify that my statements on this Notification of Change form are true and correct to the best of my knowledge.

Change in Care Coordination or HIV Primary Medical site

As of ____/____/____, the above client had a change in care coordination or HIV Primary Medical sites.

Client's Previous Care Coordination Site: ☐ **Concord** ☐ **Damien Ctr.** ☐ **Eskenazi** ☐ **LifeCare** ☐ **Step-Up**

Client's Previous Care Coordinator: _____ (please print name)

Client's New Care Coordination Site: ☐ **Concord** ☐ **Damien Ctr.** ☐ **Eskenazi** ☐ **LifeCare** ☐ **Step-Up**

Client's New Care Coordinator: _____ (please print name)

Client's Previous HIV Medical site was: ☐ **Community Inf. Diseases** ☐ **Damien Cares** ☐ **Eskenazi** ☐ **LifeCare**

☐ **Private Physician: _____**

Client's New HIV Medical site is: ☐ **Community Inf. Diseases** ☐ **Damien Cares** ☐ **Eskenazi** ☐ **LifeCare**

☐ **Private Physician: _____**

PARTICIPATION IN RYAN WHITE PROGRAM

As of ____/____/____, the above client that is currently enrolled in the Ryan White HIV Services Program wishes to no longer participate in the program.

RWSP ID#:

Marion County Public Health Ryan White HIV Services Program Notification of Change

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 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.

2. _____ *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.

3. _____ *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.

4. _____ *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, which includes Medical, Dental, and Vision services.

CARE COORDINATOR/NON-MEDICAL; MEDICAL CASE MANAGER AGREEMENT

5. _____ *CC initials* I understand as the Care Coordinator/Non-Medical or Medical Case Manager of the client 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	