Marion County Public Health
Ryan White HIV Services Program
Re-Certification Application

This application is to be used if the client's certification eligibility has NOT expired at the 6-month re-certification interval.

Do not use this application if the client is within the Attestation period, New or Re-entry. Applications will be returned if used in error.

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

Name (First, MI, Last)	Date of Birth	MCPHD RWSP ID#

Thank you for assisting your patient with the Marion County Public Health Department Ryan White HIV Services Program recertification 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 recertification 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 HIV Services Program recertification application**
2. ☐ **Attach proof of Income (income taxes for the previous year only if self-employed)**
3. ☐ **Attach copies of other insurance cards.**
4. ☐ **Attach "No Tax Form" if the client did not file income taxes for the previous year (only if self-employed)**
5. ☐ **Attach proof of Indianapolis TGA residency**
6. ☐ **Attach copy of state issued ID with current address**
7. ☐ **Attach letter from assigned Medical or Non-Medical Case Manager if the client's ID does not match the stated address on enrollment application.**
8. ☐ **Attach employer verification form filled out by client's employer verifying patient is and/or is not eligible to receive benefits through their place of employment (if applicable).**
9. ☐ **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 Ryan White HIV Services Program
Re-Certification Application

APPLICATION EFFECTIVE DATE	APPLICATION EXPIRATION DATE (6 MONTHS FROM EFFECTIVE DATE)	RWSP ID #

APPLICANT INFORMATION

First Name:	**M.I:**	**Last Name:**
Preferred First Name:	**M.I:**	**Preferred Last Name:**

Gender: ☐ **Male** ☐ **Female** ☐ **Transgender** ☐ **Male to Female** ☐ **Female to Male**	**Sex at Birth:** ☐ **Male** ☐ **Female**	**Date of birth (as stated on state ID):** ___ ___ /___ ___ /___ ___ ___ ___

Social Security Number:	**Phone number:**

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

The above client resides within the Indianapolis Transitional Grant Area (TGA) in one of the following counties: Boone, Brown, Hamilton, Hancock, Hendricks, Johnson, Marion, Morgan, Putnam and Shelby.

☐ **No Change in residency since enrollment application or most recent recertification**

☐ **Residency information has changed since enrollment application or most recent recertification.**

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:

☐ **No Change in income since enrollment application or most recent recertification attestation**

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

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

Total income here

MARION COUNTY PUBLIC HEALTH DEPARTMENT
Prevent. Promote. Protect.

RWSP ID#:

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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.

INSURANCE

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

☐ No Change in health coverage since enrollment application or most recent recertification attestation

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

In the boxes below, if changes have been made by indicating the effective dates of new insurance and expiration date of previous coverage.

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

1. _____ *Patient'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. _____ *Patient'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. _____ *Patient's Initials* I understand that this is not an entitlement program and any unruly behavior could jeopardize my enrollment into the program
4. _____ *Patient'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. _____ *Patient'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. _____ *Patient'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. _____ *Patient'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. _____ *Patient'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. _____ *Patient'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. _____ *Patient'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.

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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 patient 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	

PROGRAM 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 (please print):