

Ryan White Part B Program Application Instructions



The Ryan White Part B Program gives help to low income people living with HIV/AIDS in Maine.

<p>Use this application to see what help you qualify for.</p>	<ul style="list-style-type: none"> • You may qualify for health insurance programs or help with paying for health insurance and medications • You may qualify for help to pay for dental care, housing/utilities, and/or food • You may qualify for case management to help coordinate your needs • You don't need to fill out this application if you already have ADAP
<p>What you need to apply:</p>	<ul style="list-style-type: none"> • Proof you live in Maine • Proof of income for you and any legal dependents (spouse, children, etc.) • Information about your health insurance • We may also ask for proof of your HIV infection, especially if you are moving from another state/country
<p>How you apply:</p>	<ul style="list-style-type: none"> • Send your completed application and attachments to: Maine Ryan White Program 40 State House Station Augusta, ME 04330 Fax: (207) 287-3498
<p>What happens next?</p>	<ul style="list-style-type: none"> • Fill out the application completely and clearly. We can't process applications with missing information. • Once we receive your complete application, someone will contact you to let you know what programs you qualify for. • Please allow up to ten business days for your application to be processed. If you do not hear from us in ten business days, please call us.
<p>Get help with this application</p>	<ul style="list-style-type: none"> • Phone: (207) 287-3747. TTY users call Maine Relay 711 • Fax: (207) 287-3498 • Email: RyanWhitePartB@maine.gov

In accordance with 22 MRS §15, any person who knowingly makes any false written statements or knowingly submits any false documents to receive benefits provided by the Department may face civil penalties by the State of Maine in the Superior Court, which may include, but is not limited to, recovery of those funds disbursed.

Maine Department of Health and Human Services NONDISCRIMINATION NOTICE

The Department of Health and Human Services (“DHHS”) does not discriminate on the basis of disability, race, color, sex, gender, sexual orientation, age, national origin, religious or political belief, ancestry, familial or marital status, genetic information, association, previous assertion of a claim or right, or whistleblower activity, in admission or access to, or the operation of its policies, programs, services, or activities, or in hiring or employment practices. This notice is provided as required by and in accordance with Title II of the Americans with Disabilities Act of 1990 (“ADA”); Title VI of the Civil Rights Act of 1964, as amended; Section 504 of the Rehabilitation Act of 1973, as amended; Age Discrimination Act of 1975; Title IX of the Education Amendments of 1972; Section 1557 of the Affordable Care Act; the Maine Human Rights Act; Executive Order Regarding State of Maine Contracts for Services; and all other laws and regulations prohibiting such discrimination. Questions, concerns, complaints or requests for additional information regarding the ADA and *hiring or employment practices* may be forwarded to the DHHS ADA/EEO Coordinators at 11 State House Station, Augusta, Maine 04333-0011; 207-287-4289 (V); 207-287-1871(V); or Maine Relay 711 (TTY). Questions, concerns, complaints or requests for additional information regarding the ADA and *programs, services, or activities* may be forwarded to the DHHS ADA/Civil Rights Coordinator, at 11 State House Station, Augusta, Maine 04333-0011; 207-287-3707 (V); Maine Relay 711 (TTY); or ADA-CivilRights.DHHS@maine.gov. Civil rights complaints may also be filed with the U.S. Department of Health and Human Services, Office of Civil Rights, by phone at 800-368-1019 or 800-537-7697 (TDD); by mail to 200 Independence Avenue, SW, Room 509, HHS Building, Washington, D.C. 20201; or electronically at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Individuals who need auxiliary aids for effective communication in program and services of DHHS are invited to make their needs and preferences known to the ADA/Civil Rights Coordinator. This notice is available in alternate formats, upon request.

Ryan White Part B Program Application for Services



1. Demographics

Legal last name: _____

Legal first name: _____ Middle name: _____

Preferred name: _____

Current gender: Male
 Female
 Transgender MTF
 Transgender FTM
 Transgender Other
 Refused to report

What pronouns do you use? _____

Sex at birth: Male
 Female

Date of birth: ____ / ____ / ____

Preferred language: _____

Physical home address

Address:		City:
State: ME	Zip:	County:

Mailing address (if different)

Address:		City:
State:	Zip:	County:

Home phone: _____

Cell phone: _____

Other phone: _____

Office use only:

Date Received:

Date Complete:

Date Entered:

Approved. Ryan White ID assigned: DHS _____

HIV verification:

(circle one)

eHARS

Document provided

Not approved. Reason:

Staff initials:

Race: (check all that apply)

- Asian
 - Asian Indian
 - Chinese
 - Filipino
 - Japanese
 - Korean
 - Vietnamese
 - Other Asian
- Black or African-American
- American Indian or Alaska Native
- Other
- Native Hawaiian or Other Pacific Islander
 - Native Hawaiian
 - Guamanian or Chamorro
 - Samoan
 - Other Pacific Islander
- White

Ethnicity: (choose one)

- Non-Hispanic
- Hispanic
 - Mexican, Chicano/a
 - Puerto Rican
 - Cuban
 - Other Hispanic, Latino/a, or Spanish origin

HIV Risk Factors: (check all that apply)

- Male to male sexual contact (MSM)
- Perinatal transmission
- Not reported or not identified
- Injection drug use (IDU)
- Hemophilia/coagulation disorder
- Heterosexual contact
- Blood transfusion/blood products

HIV Status:

- CDC-defined AIDS Estimated date of AIDS diagnosis: ____/____/____
- HIV-positive, AIDS status unknown
- HIV-positive, not AIDS Estimated date of HIV diagnosis: ____/____/____

State/country of HIV diagnosis: _____

Case manager: _____

Social Security Number: _____

Country of birth: _____

Veteran of the US Armed Services? Yes No

Interpreter needed?

- No (advanced English)
- Yes, always (no English)
- Yes, sometimes (moderate English)
- Need help with written English only

Immigration status:

*** This information is only used to help us see if you can get MaineCare. We do not share this information.**

- US citizen or US national
- Asylee/refugee (legal status granted by US government)
- Asylum seeker. Date applied, if known: ____/____/____
- Lawful permanent resident (married, green card, etc.). Date granted, if known: ____/____/____
- Temporary visa
- Unknown

2. Health Care Coverage

Do you have Private Insurance or COBRA?

<input type="checkbox"/> No	<input type="checkbox"/> Yes, Plan Name:	Plan #:
Is your insurance through your employer? <input type="checkbox"/> No <input type="checkbox"/> Yes		

Do you have Medicare?

<input type="checkbox"/> No	<input type="checkbox"/> Yes, Medicare Beneficiary ID (MBI):	
If yes, check all that apply:		
<input type="checkbox"/>	Medicare Part A (covers hospital stays, surgery, lab tests, home health care)	
<input type="checkbox"/>	Medicare Part B (covers doctor visits and other outpatient care)	
<input type="checkbox"/>	Medicare Part C (called Medicare Advantage; combined coverage for hospitals, outpatient, and drugs)	
<input type="checkbox"/>	Medicare Part D (covers prescriptions, usually through a plan with Rx in the name)	
Part D Plan Name:		Plan #:

Do you have MaineCare/Medicaid/CubCare?

<input type="checkbox"/> No	<input type="checkbox"/> Yes, MaineCare #:
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Do you have military health care (VA benefits, Tricare, etc)? No Yes

Do you have Indian Health Services (IHS) insurance? No Yes

Do you have some other form of insurance or pending application?

<input type="checkbox"/> No	<input type="checkbox"/> Yes, _____ . I applied on ____/____/____ (insurance type) (date)
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3. Household and Income Information

Legal household size: _____

Legal household includes family members who are related by birth, marriage, adoption, or other legally defined dependent relationship, including legal guardianship.

Total gross annual household income: \$ _____

This is income for all members of the legal household, before deductions. If income fluctuates, please estimate what the income will be for the full year.

Individual gross annual income: \$ _____

This is income only for the person applying, before deductions. If income fluctuates, please estimate what the income will be for the full year.

4. Client Agreements and Consent to Services

Contact

Initial to show what types of contact are allowed.

- _____ It is okay to mail me newsletters and surveys at my address.
- _____ It is okay to call me at my phone number(s).
- _____ It is okay to leave me messages at my phone number(s).
- _____ It is okay to text me at this phone number: _____
- _____ It is okay to e-mail me at this address: _____

ADAP

Initial if you want ADAP.

- _____ I understand that some of my information has to be shared to get help from the AIDS Drug Assistance Program (ADAP). I understand that this information will only be shared if it is needed for me to get services. I understand that ADAP has to get information from and give information to those listed on the “**Authorization to Release Information**” form. I understand that I cannot receive ADAP if I do not complete this form.

Program Rules

Initial all areas below and sign form in order to receive services:

- _____ I understand that I have to recertify my information every six months for me to receive Ryan White Part B services. I understand that required forms will be mailed to me at my address.
- _____ I understand that information about me and the services I receive are entered into a computer system and reported to the federal government. I understand that my information has to be reported for me to receive Ryan White Part B services.
- _____ I understand that my household income must be less than the Ryan White Part B income limit to receive services. I understand that I have to give proof of income. I understand that I have to report any change in income, from any source, within 10 business days of the change.
- _____ I understand that if I receive a refund for payments the Ryan White Part B Program makes on my behalf, I must send the refund back to the Ryan White Part B Program.
- _____ All information I shared on this form is true.

I want to receive Ryan White Part B services for the next year. I understand that I have to recertify my information in six months.

_____ Printed Name

_____ Signature

_____ Date

5. Attachments

This application is not complete without each of the numbered attachments listed below:

1. Residency verification

Please submit a valid, unexpired copy of one of the following documents with your legal name on it and residential address. A post office box will only be accepted on a Maine driver's license or state ID.

- Maine driver's license or state ID
- Property tax bill or deed
- Maine vehicle registration or title
- Pay stub
- Utility bill
- Financial statement
- Concealed firearms permit
- Maine hunting/fishing license
- School transcript or report card
- Lease, rental agreement, etc.
- Tax return or W2
- Maine DHHS benefits statement

If you are staying at a homeless shelter, have an employee of the shelter write a letter saying that you are staying there.

2. Income verification

Please submit proof of your legal household's gross income from all sources. Legal household includes family members who are related by birth, marriage, adoption, or other legally defined dependent relationship, including legal guardianship. Any of the following documents are acceptable as long as they are dated in the last year:

- Social Security award letter
- Copy of Social Security check or bank statement showing Social Security deposit
- W2 tax forms
- Year-end 1099 forms
- Federal income tax return
- DHHS benefits statement

If you or someone in your legal household is working, we need 4 weeks of consecutive pay stubs dated in the last six months.

If anyone in your legal household has no income, they need to complete a Statement of No Income form.

3. HIV verification

Please attach proof of HIV diagnosis if you are moving to Maine from another state or country.

4. Authorization to Release Information

Please attach the completed Maine Department of Health and Human Services Authorization to Release Information form.