Form A - 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.

Use this application to see what help you qualify for.	• 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**
What you need to apply:	• 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
How you apply:	• Send your completed application and attachments to: **Maine Ryan White Program** **40 State House Station** **Augusta, ME 04330** **Fax: (207) 287-3498**
What happens next?	• 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.
Get help with this application	• 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.

Form A - Ryan White Part B Program
Application for Services

1. Demographics			
Legal last name: (surname/family name)			
Legal first name: (given name)			
Middle name(s):			
What name would you like us to use?			
Are you a Veteran of the US Armed Services?	☐ Yes ☐ No		
Current Gender	What pronouns do you use?	Sex at Birth	Date of Birth
☐ Male ☐ Female ☐ Transgender MTF ☐ Transgender FTM ☐ Transgender Other ☐ I do not want to answer	☐ She/Her ☐ He/Him ☐ They/Them ☐ Other: _____	☐ Male ☐ Female	_____/_____/_____ month / day / year
Social Security Number (if applicable)			
Country of Birth			
Are you a Veteran of the US Armed Services?	☐ Yes ☐ No		

Where do you live?			
Street Address			
City	State	Zip Code	County
	Maine		
Where should we send your mail? (if different)			
Street Address			
City	State	Zip Code	County

Office Use Only	☐ Approved. DHS_____	☐ Not approved. Reason:	Staff Initals:
Date Rcvd:	Date Complete:	Date Entered:	HIV verification: (check one) ☐ eHARS ☐ Document provided

Contact Information			
Home phone		Other phone	
Cell phone		Email Address	

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	
Location of HIV Diagnosis		
U.S. State or Country of HIV Diagnosis		
HIV Status		
☐ CDC-defined AIDS	Estimated date of AIDS diagnosis: _____/_____/_____	
☐ HIV-positive, AIDS status unknown		
☐ HIV-positive, not AIDS	Estimated date of HIV diagnosis: _____/_____/_____	

Immigration status (choose one)
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. Intrepretation and Translation SKIP this section if you speak and read English.	
Do you need an interpreter when speaking with us?	☐ No (advanced English) ☐ Yes, always (no English) ☐ Yes, sometimes (moderate English) ☐ Need help with written English only
If yes, what language?	
In which of these languages would you like us to send you documents?	☐ English ☐ French ☐ Portuguese ☐ Kinyarwanda

3. Health Insurance Coverage			
Do you have Private Insurance or COBRA?			
☐ No			
☐ Yes	Plan Name:		
	Is your insurance through your employer? ☐ No ☐ Yes		
Do you have Medicare?			
☐ No			
☐ Yes	Medicare Beneficiary ID number (MBI):		
	☐ Medicare Part A (covers hospital stays, surgery, lab tests, home health care)		
	☐ Medicare Part B (covers doctor visits and other outpatient care)		
	☐ Medicare Part C (called Medicare Advantage; combined coverage for hospitals, outpatient, and drugs)		
	☐ Medicare Part D (covers prescriptions, usually through a plan with Rx in the name)	Part D Plan Name	
		Part D Plan Number	

Do you have MaineCare/Medicaid/CubCare?	
☐ No	
☐ Yes	MaineCare Number:
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?	
☐ No	
☐ Yes	Insurance type:
	Date you applied for the insurance plan: _____/_____/_____

4. Household and Income Information

Legal household size: _____ (number in household)
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.

5. Case Management

A Case Manager can help you with medical care and insurance. They can also help you work on your goals for things like transportation, housing, and legal services. Case management is free. It is offered by local organizations.

If you have a Case Manager now, who are they?	Name:	Agency:
If you do not have a Case Manager, do you want help connecting with one?		☐ No ☐ Yes

7. Client Agreements

Contact → Initial on lines to show what types of contact are allowed.

_____ It is okay to mail me 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 my phone number(s).

_____ It is okay to e-mail me at my email address.

8. Consent to Services

Program Rules → Initial all areas below and sign form in order to receive services.

_____ 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.

_____ I understand that I have to recertify my information every 12 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 one year.

_____	_____	_____
Printed Name	Signature	Date

9. 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 benepfits 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.