



# NORTH DAKOTA RYAN WHITE PROGRAM PART B APPLICATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DISEASE CONTROL AND FORENSIC PATHOLOGY  
SFN 54191 (02-2026)

The following information is required to assess your North Dakota Ryan White Part B Program eligibility.

- Identity/Age:** Bring records that prove your identity and age (e.g., driver's license, passport).
- Income:** Bring records to show your gross (before taxes) income for all household members (e.g., most recent tax form, wage stubs, SSDI, SSI).
- Residence:** Bring records to show where you live (e.g., driver's license, rent receipts, utility bills). You must be able to provide a North Dakota ID within 60 days of applying.
- Health Coverage:** Bring a copy of your private insurance, Medicaid or Medicare cards (front and back).

Submit this completed form and the listed documents to the regional Ryan White coordinator or mail/fax to:  
Ryan White Program; 600 E Boulevard Ave, Dept. 325; Bismarck, ND 58505-0250.

Secure fax: 701-328-0338; Telephone: 701-328-2378 or 800-472-2180; Website: [hhs.nd.gov/HIV/RyanWhite](https://hhs.nd.gov/HIV/RyanWhite)

## Ryan White Program Information

Ryan White Agency	RW Number	Member ID	<input type="checkbox"/> Enrollment <input type="checkbox"/> Re-enrollment
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## Applicant Information

First Name		Last Name		Social Security Number	
Street Address				City	State
Telephone Number				Email Address	
Date of Birth				Country of Birth	
Sex at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female				Hispanic or Latino <input type="checkbox"/> Yes <input type="checkbox"/> No	
Race (check all that apply) <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Black/African American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> White					
Is there someone we can contact on your behalf? <input type="checkbox"/> Yes <input type="checkbox"/> No			Is this person aware of your diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No		
When can we contact this person? <input type="checkbox"/> In case of an emergency <input type="checkbox"/> If we are not able to reach you <input type="checkbox"/> To discuss your RW eligibility and benefits					
Contact Name		Phone Number		Relationship	
Physician's Name		Clinic		Pharmacy	
Date of Initial Diagnosis (month/year)			City/State or Country (if outside the US) of Diagnosis		
Citizenship Status (optional): We ask this information to help determine which health coverage you may be eligible for. <input type="checkbox"/> Citizen <input type="checkbox"/> Permanent Resident <input type="checkbox"/> Temporary Visa <input type="checkbox"/> Undocumented <input type="checkbox"/> Other:					
Employment Status <input type="checkbox"/> Employed full-time <input type="checkbox"/> Employed part-time <input type="checkbox"/> Self-employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Student					
Employer's Name					

## Household Characteristics

Housing Type (please select one) <input type="checkbox"/> Permanent housing (apartment, house, boarding house) <input type="checkbox"/> Rent <input type="checkbox"/> Own <input type="checkbox"/> Temporary (transitional housing for the homeless, staying with friends or family) <input type="checkbox"/> Unstable (emergency shelter, vehicle, streets, hotel, or motel paid for by the emergency funding) <input type="checkbox"/> Incarcerated (jail or another correctional agency excluding prison)	
Are you receiving housing assistance (HOPWA, public housing, Section 8)? <input type="checkbox"/> No <input type="checkbox"/> Yes, please describe:	Are you a veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No
Describe current living arrangement (stability, safety, affordability)	Cost/month

## Household Size and Income

Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Legally Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other:				
Name	Relationship	Date of Birth	Type of Income	Monthly Gross Income (before taxes)
	Self			
Household Size		Total Monthly Household Income		
Household Federal Poverty Level (to be completed by the case manager)				

## Statement of No Income

If you currently have no income, please fill out the following information. <input type="checkbox"/> I did not file income tax in 20____. This statement is true to the best of my knowledge. <input type="checkbox"/> I currently have no income and have not received income since:
Please explain how you cover your living expenses if you report no current income.

## Current Health Coverage Type

Select your current health coverage and provide a copy of your cards (front and back).  <input type="checkbox"/> ND Medicaid: <input type="checkbox"/> Traditional <input type="checkbox"/> Expansion <input type="checkbox"/> Recipient Liability: \$ _____ <input type="checkbox"/> Medicare: <input type="checkbox"/> Part A/B <input type="checkbox"/> Part D <input type="checkbox"/> Medicare Advantage (Part C) <input type="checkbox"/> Supplemental (Medigap) <input type="checkbox"/> Medicare Cost <input type="checkbox"/> Private Insurance through an employer or family member <input type="checkbox"/> Marketplace (HealthCare.gov) <input type="checkbox"/> Ryan White program pays my Marketplace premium* <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> VA, Tricare, or other military care <input type="checkbox"/> IHS (Indian Health Services) <input type="checkbox"/> Other: <input type="checkbox"/> I currently have no health coverage as of (date)*:
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## Current Health Coverage Information

Insurance Provider (e.g., BCBS)	Member ID	Coverage Start Date
Insurance Provider (e.g., BCBS)	Member ID	Coverage Start Date
Has your health coverage changed in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure		If yes, date of change:

\*Complete the next section only if you are **uninsured or receive RW premium assistance for Marketplace insurance**. If you have health coverage or have Marketplace insurance but pay your own premiums, please skip to the next page.

## Health Coverage Screening and Confirmation

<p><b>A. Medicaid Screening</b></p> <p><input type="checkbox"/> <b>My annual income (past 12 months) is below \$20,000.</b> In the past 6 months, I have applied for ND Medicaid and:</p> <p><input type="checkbox"/> I was denied because of: <input type="checkbox"/> Income <input type="checkbox"/> Citizenship status <input type="checkbox"/> Incomplete application <input type="checkbox"/> Other:</p> <p><input type="checkbox"/> My application is still pending. Date applied:</p> <p><input type="checkbox"/> I have <b>not</b> applied for ND Medicaid in the past 6 months.</p>	
<p><b>B. Employer Insurance Screening</b></p> <p><input type="checkbox"/> <b>My annual income (past 12 months) is above \$20,000.</b> I, or someone in my household, is employed, but:</p> <p><input type="checkbox"/> My employer does <b>not</b> offer health insurance.</p> <p><input type="checkbox"/> No one in my household is eligible for employer-based insurance that covers me.</p> <p><input type="checkbox"/> Other:</p> <p>All employed household members <b>must</b> have their employer complete the <a href="#">Employer Coverage Tool</a>.</p>	
<p><b>C. Ryan White Payer of Last Resort Requirement</b></p> <p>If you are eligible for health coverage (through Medicaid, Medicare, or employer insurance) and do <b>not</b> enroll, you are <b>not in compliance</b> with the Ryan White Part B “payer of last resort” policy. This means you will be <b>ineligible</b> for Ryan White-covered services until you obtain appropriate coverage.</p> <ul style="list-style-type: none"> <li>• If you are waiting for coverage to start, Ryan White may temporarily assist for <b>up to three months</b>.</li> <li>• If you are found <b>not eligible</b> for Medicaid, Medicare, or employer coverage, you <b>must</b> enroll in a <b>Marketplace plan</b> during the next open enrollment period. The Ryan White Program can help pay your monthly premium.</li> <li>• If you <b>do not enroll</b> in available coverage during open enrollment, your Ryan White Part B eligibility will be <b>suspended for one year</b> or until you enroll in health coverage.</li> </ul> <p>_____ (initial here) <b>I understand that the Ryan White program is a payer of last resort and may only cover services if no other payers are available. This means that if I am eligible but do not enroll in health coverage, I will not be able to receive Ryan White services until I gain appropriate coverage.</b></p>	
<p><b>Case Managers Use Only:</b></p> <p><input type="checkbox"/> Applicant is <b>not eligible</b> for any health coverage at this time and qualifies for Ryan White services.</p> <p><input type="checkbox"/> Applicant is <b>eligible</b> for public or private coverage and will receive a <b>three-month window</b> of RW coverage, ending on: _____.</p> <p><input type="checkbox"/> Applicant is <b>not in compliance</b> with Ryan White policies and does <b>not qualify</b> for RW services.</p>	
Client/Guardian Signature	Date
Case Manager Signature	Date

**Ryan White Services and Basic Needs Assessment (Please select areas where you need help)**

RW-Funded Services <input type="checkbox"/> Case management <input type="checkbox"/> Medical bills <input type="checkbox"/> Medications <input type="checkbox"/> Insurance premiums <input type="checkbox"/> Dental care <input type="checkbox"/> Vision care	<input type="checkbox"/> Mental health <input type="checkbox"/> Substance use treatment <input type="checkbox"/> HIV individual/peer support <input type="checkbox"/> HIV support groups <input type="checkbox"/> Housing/utilities <input type="checkbox"/> Transportation	Basic Needs <input type="checkbox"/> Food and clothing <input type="checkbox"/> Phone access <input type="checkbox"/> Paying bills/money management <input type="checkbox"/> Finding/keeping a job <input type="checkbox"/> Language/cultural barriers <input type="checkbox"/> Legal/incarceration issues <input type="checkbox"/> Citizenship/immigration
Other		

**Medical Care Information**

When was your last visit with your HIV provider? <input type="checkbox"/> Within 6 months <input type="checkbox"/> Within 12 months <input type="checkbox"/> Longer than 12 months		
Are you currently virally suppressed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know	Is your CD4 count above 200 cells/mL? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know	
What HIV medications are you currently taking?	Have you missed any doses in the past 12 months? <input type="checkbox"/> No <input type="checkbox"/> Yes, describe:	
Have you had unprotected sex, multiple/anonymous sex partners, or shared needles with anyone in the past 12 months? <input type="checkbox"/> No <input type="checkbox"/> Decline to answer <input type="checkbox"/> Yes, please describe:		
How were you exposed to HIV? <input type="checkbox"/> Male-to-male sex <input type="checkbox"/> Male-to-female sex <input type="checkbox"/> Hemophilia/coagulation disorder <input type="checkbox"/> Perinatal (mother to child) <input type="checkbox"/> Organ transplant or blood transfusion <input type="checkbox"/> Work-related exposure <input type="checkbox"/> Injection drug use <input type="checkbox"/> I'm not sure		
Are you currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	If yes, are you receiving prenatal care? <input type="checkbox"/> Yes <input type="checkbox"/> No	Estimated delivery date

**Substance Use and Mental Health Assessment**

Are you a tobacco user? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Former	Are you interested in quitting? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	Are you exposed to second-hand smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you currently use drugs or alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Former use	If yes, check all that apply <input type="checkbox"/> Alcohol <input type="checkbox"/> Street <input type="checkbox"/> Prescription <input type="checkbox"/> Injecting	
Would you like a referral? <input type="checkbox"/> Substance Abuse Counseling <input type="checkbox"/> Syringe Services <input type="checkbox"/> Tobacco Cessation <input type="checkbox"/> No <input type="checkbox"/> Not Applicable		
Do you have mental health concerns? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Former	Comments	
Are you receiving counseling/treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	Are you interested in a referral? <input type="checkbox"/> Yes <input type="checkbox"/> No	

**Ryan White Program Partners - Direct Client Contact**

Would you like to be contacted by Canopy Medical Clinic about mental health and peer services? <input type="checkbox"/> Yes <input type="checkbox"/> No
Would you like to be contacted by Shine Bright & Live about their events and services? <input type="checkbox"/> Yes <input type="checkbox"/> No
Would you like to receive information about participating in the ND HIV Advisory Board as a consumer/adviser about issues related to your status and care? <input type="checkbox"/> Yes <input type="checkbox"/> No

## To Be Completed by the Case Manager – Acuity Scale

Life Area & Score	0 points Self Mgmt.	1 point Basic Need	2 points Moderate Need	3 points High Need
<b>Medical Case Management</b>				
<b>Linkage and Retention in Medical Care</b>  <b>Acuity Score:</b>	<input type="checkbox"/> Client attended all HIV medical appointments in the last 12 months.	<input type="checkbox"/> Client missed one appointment in the last 12 months or has rescheduled multiple appointments.	<input type="checkbox"/> Client missed more than one medical appointment in the last 12 months.	<input type="checkbox"/> No reported labs in the past 12 months. Client is: <input type="checkbox"/> newly diagnosed <input type="checkbox"/> pregnant <input type="checkbox"/> immunocompromised <input type="checkbox"/> released from a correctional facility within the past 90 days <input type="checkbox"/> is/was hospitalized or used ER in the last 30 days
<b>Understanding of HIV &amp; Risk Behavior</b>  <b>Acuity Score:</b>	<input type="checkbox"/> Understands risks & practices harm reduction behavior and communicates with sexual partners about safer sex (e.g. condom use, PrEP, testing)	<input type="checkbox"/> Understands risks and practices harm reduction most of the time.	<input type="checkbox"/> Has poor knowledge and engages in risky behaviors. Viral load detectable. Needs partner services.	<input type="checkbox"/> Frequently engages in risky behaviors. Not virally suppressed. High risk for HIV transmission. Needs partner services.
<b>Medication Adherence</b>  <b>Acuity Score:</b>	<input type="checkbox"/> Complete medication adherence reflected in the undetectable viral load.	<input type="checkbox"/> Misses doses occasionally with continued viral load suppression.	<input type="checkbox"/> Misses doses frequently. Has a detectable viral load below 200 copies/mL.	<input type="checkbox"/> Misses doses daily and has a viral load over 200 copies/mL. Needs adherence counseling.
<b>Health Coverage</b>  <b>Acuity Score:</b>	<input type="checkbox"/> Has medical coverage. Able to access medical care.	<input type="checkbox"/> Enrolled in health coverage but requires support to maintain coverage.	<input type="checkbox"/> Has medical coverage but requires ADAP premium assistance and CM support to maintain coverage.	<input type="checkbox"/> No health coverage. <input type="checkbox"/> Not eligible for public or private coverage. <input type="checkbox"/> Eligible but not enrolled.
<b>Non-Medical Case Management</b>				
<b>Basic Needs</b>  <b>Acuity Score:</b>	<input type="checkbox"/> Food, clothing, and other basic items available through client's own means. <input type="checkbox"/> Has ongoing access to assistance programs that maintain basic needs consistently. <input type="checkbox"/> Able to perform activities of daily living independently (ADL)	<input type="checkbox"/> Basic needs met on a regular basis with occasional need for help accessing assistance programs. <input type="checkbox"/> Unable to routinely meet basic needs without emergency assistance. <input type="checkbox"/> Needs assistance to perform some ADL weekly.	<input type="checkbox"/> Routinely needs help accessing assistance programs for basic needs. <input type="checkbox"/> History of difficulties in accessing assistance programs. <input type="checkbox"/> Often w/o food, clothing, or other basic needs. <input type="checkbox"/> Needs in-home ADL assistance.	<input type="checkbox"/> Has no access to food. <input type="checkbox"/> Without most basic needs. <input type="checkbox"/> Unable to perform most ADL. <input type="checkbox"/> No home to receive assistance with ADL.
<b>Mental Health</b>  <b>Acuity Score:</b>	<input type="checkbox"/> No history of mental health problems. No need for referral.	<input type="checkbox"/> Past problems and/or reports current difficulties/stress – is functioning or already engaged in mental health care.	<input type="checkbox"/> Having trouble in day-to-day functioning. Requires significant support. Needs referral to mental health care.	<input type="checkbox"/> Danger to self or others and needs immediate intervention. Needs referral to mental health care.
<b>Substance Use</b>  <b>Acuity Score:</b>	<input type="checkbox"/> No difficulties with substance use. No referrals needed.	<input type="checkbox"/> Past problems but currently in recovery. Not impacting ability	<input type="checkbox"/> Current substance use – willing to seek help. Impacts ability	<input type="checkbox"/> Current substance use – not willing to seek help. Unable to function daily or maintain medical care.

Life Area & Score	0 points Self Mgmt.	1 point Basic Need	2 points Moderate Need	3 points High Need
		to function daily or access medical care.	to function and access medical care.	
<b>Housing</b> <i>Acuity Score:</i>	<input type="checkbox"/> Living in clean, stable housing. Does not need assistance.	<input type="checkbox"/> Stable housing (subsidized or not). Occasionally needs housing assistance (<2 times per year).	<input type="checkbox"/> Temporary housing (subsidized or not). Frequent violations and eviction notices and history of homelessness.	<input type="checkbox"/> Unstable housing. Currently facing eviction or homelessness.
<b>Language and Cultural Barriers</b> <i>Acuity Score:</i>	<input type="checkbox"/> No language/cultural barriers.	<input type="checkbox"/> Some language/cultural barriers that do not majorly affect access to medical care or services.	<input type="checkbox"/> Language & cultural barriers that prevent client from accessing medical care and services.	<input type="checkbox"/> Language/cultural barriers. Client is not able to access medical care or treatment without translation services and CM assistance.
<b>Transportation</b> <i>Acuity Score:</i>	<input type="checkbox"/> Has consistent and reliable access to transportation with no need for agency support.	<input type="checkbox"/> Occasionally needs transportation assistance to stay in medical care.	<input type="checkbox"/> Has a car or a bus pass but requires CM assistance in coordinating and reimbursing transportation.	<input type="checkbox"/> Limited or no access to transportation (language, cognitive ability, mental health) which impacts access to medical care and services.
<b>Total Points:</b>	<b>Add up the total points from each line to determine the total</b>			
	0 pts: Self-Management		1-10 pts: Basic Case Management	
	11-20 pts: Moderate Case Management		21-30 pts: Intensive Case Management	
Notes				

### Counseling and Referrals Provided (for case managers)

Referral to HIV medical care <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	Referral to health coverage enrollment services <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable
HIV risk reduction counseling provided <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	Medication adherence counseling provided <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable
Referral to substance abuse services <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	Referral to mental health services <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable
Referral to social services <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	Referral to housing services <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable
Other	
Notes	

## ND Ryan White Program Part B Client Rights and Responsibilities

### Client's Rights:

As a participant in the ND Ryan White Program, you have the right to:

- Be treated with respect, dignity, consideration, and compassion.
- Receive Ryan White case management and other services free of discrimination.
- Actively participate in developing your care and service plan, including setting goals.
- Receive clear information about available services, eligibility requirements, your care plan, and any changes that may affect your services.
- Receive services on time and be informed of any delays or service limitations.
- Receive referrals to other appropriate services when needs cannot be met directly by the program.
- Have your Ryan White records be treated confidentially.
- File a grievance about services you are receiving or the denial of services.

### Client's Responsibilities:

As a participant in the North Dakota Ryan White Program, you agree to:

- Provide complete and truthful information regarding income, insurance status, residency, HIV status, and other eligibility requirements.
- Treat staff, providers, and other clients with respect and courtesy. Harassment, threats, or violence will not be tolerated.
- Annually complete the re-enrollment by **April 30<sup>th</sup>** for continued program eligibility.
- Attend scheduled appointments, arrive on time, and notify staff in advance if you need to cancel or reschedule.
- Work collaboratively with your case manager to develop and follow your care or service plan to the best of your ability.
- Notify your case manager promptly of changes in contact information, income, health coverage status, or other factors that may affect services.
- Inform your providers of your health coverage by showing them your health insurance card(s) and the Outpatient Ambulatory Medical Services (Ryan White) card.
- Seek services from Medicaid participating providers when available.
- Notify your case manager of any bills within 30 days of the statement date.
- Follow the Ryan White case manager's directions to get assistance from other available programs and services, including enrolling in eligible health coverage.
- Stay in care by visiting your doctor regularly and taking prescribed medication to ensure your health and well-being.
- Follow program rules, procedures, and use RW-funded services only for their intended purpose and in accordance with program guidelines.

I acknowledge that I have read and understand the above information.

Client/Guardian Signature	Date
Case Manager Signature	Date

## ND Ryan White Program Part B Client Release of Information

I, \_\_\_\_\_, authorize ND Ryan White Program staff or their agents to discuss my case and diagnosis (if necessary) with the providers listed to obtain and maintain services that I may qualify for:

HIV/primary care provider and clinic staff	Insurance enrollment assisters
Ryan White program staff	ND Insurance providers
Other providers (pharmacist, dentist, etc.)	Medicaid representative
Social workers	Housing assistance coordinator
County human service worker	Peer navigators or advocates (Canopy Medical Clinic)
Other:	Other HIV services (Shine Bright & Live)

I also authorize the ND Ryan White program to check with private insurers and employers about health or dental insurance I may have. This authorization is for the sole purpose of obtaining eligibility information, dates, and premium details to assist with insurance premiums and ensure appropriate health coverage.

**This permission will expire one year from the date of my signature.** I may revoke this authorization at any time by writing to the ND Ryan White Program. If I revoke this authorization, ND Ryan White Program staff and the persons indicated above may act on the information that has been released up to the date of that revocation.

I understand that information about me is protected by state and federal privacy laws. I understand that this information cannot be released without my consent, except as provided by law.

I understand that I do not have to sign this authorization form. If I choose not to sign this form, it may limit the services that may be offered to me. If I sign this form, I have the right to receive of a copy of the completed authorization.

Client/Guardian Signature	Date
Case Manager Signature	Date

## ND Ryan White Program Part B Certification

I certify that the information provided in this application is true, complete, and accurate to the best of my knowledge. I understand that providing false or incomplete information may result in denial or termination of services and may require repayment of services received.

I understand **that the Ryan White program is a payer of last resort and may only cover services if no other payers are available. This means that if I am eligible but do not enroll in health coverage, I will not be able to receive Ryan White services until I gain appropriate coverage.**

I understand that I must **re-enroll each year by April 30th** to remain enrolled in the program.

Client/Guardian Signature	Date
Case Manager Signature	Date