ND RYAN WHITE PART B PROGRAM ENROLLMENT APPLICATION
NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF SEXUALLY TRANSMITTED AND BLOODBORNE DISEASES
SFN 54191 (Rev. 07-2021)

The following information is required to assess your eligibility for the North Dakota Ryan White Part B Program.
☐ **Identity/Age**: Bring records that prove your identity and age (e.g. driver's license).
☐ **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 (driver's license, rent receipts, utility bills). You must be able to provide a state ID within 60 days of applying.
☐ **Health insurance**: Bring a copy of the insurance card (front and back).
☐ **Medicaid/Medicare**: Bring a copy of your Medicaid and Medicare cards (front and back).

Please complete this form to the best of your knowledge and provide with the listed documentation to the local Ryan White case manager. You may also fax to **701-328-0338** or mail to **Ryan White Part B Program; 600 E Boulevard Ave, Bismarck, ND 58505-0200**. For questions, please call 701-328-2378 or visit ndhealth.gov/hiv.

Applicant's Information

Ryan White Case Management Site	ND Ryan White Client Number	ND ADAP Client Number		
First Name	Last Name	Social Security Number		
Street Address		City	State	ZIP Code
Mailing Address (if different)		City	State	ZIP Code
Primary Telephone Number	Secondary Telephone Number	Email Address		
Date of Birth	Country of Birth	Primary Language		
Gender ☐ Male ☐ Female ☐ Transgender M to F ☐ Transgender F to M ☐ Other:			Sexual Orientation	
Race (check all that apply) ☐ Asian ☐ American Indian ☐ Black/African American ☐ Pacific Islander ☐ White			Hispanic or Latino ☐ Yes ☐ No	
Emergency Contact's Name	Emergency Contact's Phone Number	Relationship		
Physician's Name	Clinic	Pharmacy		
Date of Initial Diagnosis (month/year)	City/State or Country (if outside US) of Diagnosis			
Risk Category (please select all that apply) ☐ Men having sex with men (MSM) ☐ Heterosexual contact ☐ Injection drug use (IDU) ☐ Hemophilia/coagulation disorder ☐ Perinatal (mother to child) ☐ Organ transplant or blood transfusion ☐ Work related exposure ☐ Unknown				
Citizenship Status ☐ Citizen ☐ Permanent Resident ☐ Temporary Visa ☐ Undocumented				
Employment Status ☐ Employed full-time ☐ Employed part-time ☐ Self-employed ☐ Unemployed ☐ Retired ☐ Disabled ☐ Student				
Employer's Name				

Insurance Information

Select the type of health coverage you currently have and provide a copy of the insurance card (front and back).

Private Insurance	Medicaid	Medicare	Other	☐ **Marketplace Insurance paid by the Ryan White program**	☐ **I do not have health coverage since (date):**
☐ Employer based ☐ Private individual ☐ Dental ☐ Vision ☐ Other:	☐ Traditional ☐ Expansion ☐ Dually Eligible (Medicaid/Medicare)	☐ Part A/B ☐ Part D (drug coverage)	☐ VA ☐ IHS ☐ Other:	If selected, please complete the Health Coverage Screening and Attestation	

Insurance Provider's Name (e.g. BCBS)	Member ID	Policy Start Date
Insurance Provider's Name (e.g. BCBS)	Member ID	Policy Start Date

Health Coverage Screening and Attestation

Please complete this section if you currently have no health coverage or are enrolled in the Marketplace Health Insurance paid by the Ryan White program.

☐ **My income for the past 12 months is below $20,000.**

- ☐ I have applied for ND Medicaid in the past 6 months and have been denied due to my:
  - ☐ Income ☐ Citizenship/immigration status ☐ Having incomplete application
- ☐ I have not applied for ND Medicaid in the past 6 months.

☐ **My income for the past 12 months is above $20,000.** I, or other members of my household, are employed but:

- ☐ My employer does not offer health insurance.
- ☐ No one in my household is offered health insurance through employment in which I am an eligible party.

All employed members in the household must have their employer(s) complete the Employer Coverage Tool.

If you are eligible for and have not obtained health coverage through Medicaid, Medicare or Private Employer Based Plans, you are not in compliance with Ryan White Part B polices regarding "payer of last resort." This will render you ineligible for Ryan White Covered Services until appropriate coverage is obtained. Consideration will be made to provide medications and services for a **period of up to three months** to cover services until plans may become active

If you have applied for and are not eligible for Medicaid, Medicare or Private Employer Based Plans, you must enroll in a qualified health plan through the Health Insurance Marketplace with a Ryan White approved plan during the next open enrollment period. The Ryan White program can pay your portion of the insurance premium. Failure to enroll in a health insurance plan during the next available enrollment period will result in a **one-year suspension** from the Ryan White Part B program or until health insurance coverage is obtained.

_____(please initial) I understand that Ryan White Part B program is a payer of last resort and may only cover services when there is no other payer available. This means that if I am eligible for health coverage and I do not enroll, Ryan White will suspend my eligibility for Ryan White Part B until I gain appropriate coverage.

For Case Managers:

☐ This applicant is currently not eligible for any health coverage and qualifies for Ryan White services.

☐ This is applicant eligible for public or private health coverage and should receive 3 month window period of RW coverage ending on: _____.

☐ This client is not in compliance with Ryan White Policies and does not qualify for Ryan White services.

Client/Guardian Signature	Date
Case Manager Signature	Date

Household Characteristics

Housing Type (please select one)

☐ Permanent housing (apartment, house, boarding house) ☐ Rent ☐ Own

☐ Temporary (transitional housing for homeless, staying with friends or family)

☐ Unstable (emergency shelter, jail, vehicle, streets, hotel or motel paid for by the emergency funding)

Are you receiving housing assistance (HOPWA, public housing, Section 8)? ☐ No ☐ Yes, please describe:

Describe current living arrangement (stability, safety, affordability)	Cost/month

In the past 12 months, what was the most unstable housing status that you experienced?

☐ Homeless or unstable housing ☐ Temporary housing ☐ Stable or permanent housing

Household Size and Income

Marital Status

☐ Single ☐ Married ☐ Legally Separated ☐ Divorced ☐ Widowed ☐ Other:

List every family member who lives with you (legal spouse, biological/adopted/stepchildren) and anyone you claim as a dependent on your taxes. List their income if applicable. Attach additional sheets if needed.

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.

☐ I did not file income tax in 20____. This statement is true to the best of my knowledge.

☐ I currently have no income and have not received income since:

Please explain how your living expenses are met if you report no current income.

Ryan White Services Assessment

Please select which ND Ryan White services and service reimbursements you need.

☐ Case Management
☐ Outpatient HIV medical care
☐ Dental care
☐ Mental health
☐ Rent and Utility assistance
☐ HIV Support Groups
☐ Medications (ADAP)
☐ Insurance premiums (ADAP)
☐ Vision care
☐ Nutritional supplements
☐ Transportation

Other

Basic Needs Assessment

Please select areas where you need referrals and assistance.

- ☐ Housing/utilities
- ☐ Medical bills
- ☐ Food and clothing
- ☐ Paying bills/money management
- ☐ Citizenship/immigration status
- ☐ Language/cultural barriers
- ☐ Legal/incarceration issues
- ☐ Finding/keeping a job

Other

Retention in Care and HIV Risk Assessment

When was your last visit with your HIV provider?
☐ Within past 6 months ☐ Within past 12 months ☐ Longer than 12 months

Are you currently virally suppressed? ☐ Yes ☐ No ☐ I do not know	Is your CD4 count above 200 cells/mL? ☐ Yes ☐ No ☐ I do not know
What HIV medications are you currently taking?	Have you missed any doses in the past 12 months? ☐ No ☐ Yes, describe:

Have you had unprotected sex, multiple or anonymous sex partners, or shared needles with anyone in the past 12 months? ☐ No ☐ Decline to answer ☐ Yes, please describe:

Recommended Screenings for Persons Living with HIV

Have you been tested for syphilis in the past 12 months? ☐ Yes ☐ No ☐ Not sexually active		Date tested	Test result
Have you been tested for chlamydia and gonorrhea in the past 12 months? ☐ Yes ☐ No ☐ Not sexually active		Date tested	Test results
Are you currently pregnant? ☐ Yes ☐ No ☐ Not Applicable	If yes, are you receiving prenatal care? ☐ Yes ☐ No	Estimated delivery date	

Substance Use and Mental Health Assessment

Are you a tobacco user? ☐ Yes ☐ No ☐ Former	Are you interested in quitting at this time? ☐ Yes ☐ No ☐ Not Applicable	Are you exposed to second-hand smoke? ☐ Yes ☐ No

Do you currently misuse drugs or alcohol? ☐ Yes ☐ No ☐ Former use	If yes, check all that apply ☐ Alcohol ☐ Street ☐ Prescription ☐ Injecting

Would you like a referral?
☐ Substance Abuse Counseling ☐ Syringe Services ☐ Tobacco Cessation ☐ No ☐ Not Applicable

Comments

Do you have mental health concerns? ☐ Yes ☐ No ☐ Former	Comments
Do you have a history of trauma in your life? ☐ Yes ☐ No	Do you have physical or emotional abuse concerns? ☐ Yes ☐ No, I feel safe
Are you receiving counseling/treatment? ☐ Yes ☐ No ☐ Not Applicable	Are you interested in getting help? ☐ Yes ☐ No ☐ Not Applicable

To Be Completed by Case Manager – Acuity Scale

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

Life Area & Score	0 points Self Mgmt.	1 point Basic Need	2 points Moderate Need	3 points High Need
Mental Health *Acuity Score:*	☐ No history of mental health problems. No need for referral.	☐ Past problems and/or reports current difficulties/stress – is functioning or already engaged in mental health care.	☐ Having trouble in day-to-day functioning. Requires significant support. Needs referral to mental health care.	☐ Danger to self or others and needs immediate intervention. Needs referral to mental health care.
Substance Use *Acuity Score:*	☐ No difficulties with substance use. No referrals needed.	☐ Past problems but currently in recovery. Not impacting ability to function daily or access medical care.	☐ Current substance use – willing to seek help. Impacts ability to function and access medical care.	☐ Current substance use – not willing to seek help. Unable to function daily or maintain medical care.
Housing *Acuity Score:*	☐ Living in clean, stable housing. Does not need assistance.	☐ Stable housing (subsidized or not). Occasionally needs housing assistance (<2 times per year).	☐ Temporary housing (subsidized or not). Frequent violations and eviction notices and history of homelessness.	☐ Unstable housing. Currently facing eviction or homelessness.
Language and Cultural Barriers *Acuity Score:*	☐ No language/cultural barriers.	☐ Some language/cultural barriers that do not majorly affect access to medical care or services.	☐ Language & cultural barriers that prevent client from accessing medical care and services.	☐ Language/cultural barriers. Client is not able to access medical care or treatment without translation services and CM assistance.
Transportation *Acuity Score:*	☐ Has consistent and reliable access to transportation with no need for agency support.	☐ Occasionally needs transportation assistance to stay in medical care.	☐ Has a car or a bus pass but requires CM assistance in coordinating and reimbursing transportation.	☐ Limited or no access to transportation (language, cognitive ability, mental health) which impacts access to medical care and services.
Total Points:	**Add up the total points from each line to determine the total** 0 pts: Self-Management 11-20 pts: Moderate Case Management		1-10 pts: Basic Case Management 21-30 pts: Intensive Case Management	
Notes:				

Counseling and Referrals Provided (for case managers)

Referral to HIV medical care ☐ Yes ☐ No ☐ Not Applicable	Referral to health coverage enrollment services ☐ Yes ☐ No ☐ Not Applicable
HIV risk reduction counseling provided ☐ Yes ☐ No ☐ Not Applicable	Medication adherence counseling provided ☐ Yes ☐ No ☐ Not Applicable
Referral to substance abuse services ☐ Yes ☐ No ☐ Not Applicable	Referral to mental health services ☐ Yes ☐ No ☐ Not Applicable
Referral to social services ☐ Yes ☐ No ☐ Not Applicable	Referral to housing services ☐ Yes ☐ No ☐ Not Applicable
Other referrals	

ND Ryan White Program Part B Client Rights and Responsibilities

Client's Rights:

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

- Be treated with respect, dignity, consideration, and compassion.
- Receive case management services Be treated with respect, dignity, consideration, and compassion.
- Receive case management services free of discrimination on the basis of race, color, sex/gender, ethnicity, national origin, religion, age, class, sexual orientation, physical and/or mental ability.
- Participate in creating a plan for case management services.
- Be informed about services and options available to you.
- Reach an agreement with your case manager about the frequency of contact you will have, either in person or over the telephone.
- Have your medical records and case management records be treated confidentially.
- File a grievance about services you are receiving or denial of services

Client's Responsibilities:

As a participant in the North Dakota Ryan White Program Part B, you have the responsibility to:

- Treat other clients and staff of this agency with respect and courtesy.
- Protect the confidentiality of other clients you may encounter at this agency.
- Not subject case managers, staff, or other clients to physical, sexual, verbal and/or emotional abuse or threats.
- Participate as much as you are able in creating a plan for case management.
- Let your case manager know any concerns you have about your case management plan or changes in your needs.
- Make and keep appointments to the best of your ability, or if possible, to phone to cancel or change an appointment time.
- Stay in communication with your case manager by informing him/her of changes in your address or phone number, income, and responding to the case manager's calls or letters to the best of your ability.
- Provide your case manager any requests for payment of bills within 30 days of the statement date and provide required documentation.
- Follow case manager directions to get assistance from other available programs and services.
- Stay in care by visiting your doctor regularly and take prescribed medication to ensure your health and well-being.
- Every six months recertify your eligibility and enrollment in the ND Ryan White Part B program. You **must reenroll by April 30th and recertify by October 31st** each year for continued Ryan White eligibility.

I understand the above information, and I have received a copy for my records.

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:

Case managers	Advocates
County financial worker	ND Medicaid representative
Physician	Clinic staff
Insurance enrollment assisters	Insurance providers
Other medical care providers (pharmacist, dentist, etc.)	Social worker

I also authorize 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 information in order 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 my information that has been released up to the date of that revoke.

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 or curtail 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 hereby certify that the representation of my income, insurance and other financial assistance is a true and accurate statement and that eligibility requirements as listed above have been met and documented.

I understand my Rights and Responsibilities, including completing eligibility documentation every 6 months, and reporting changes in income, insurance status, or residency to my case manager right away.

I understand that I must **reenroll each year by April 30 and recertify by October 31 for continued eligibility.** If I fail to do so, I will become ineligible to receive services through the ND Ryan White Program.

Client/Guardian Signature	Date
Case Manager Signature	Date