# NORTH DAKOTA RYAN WHITE PROGRAM PART B APPLICATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DISEASE CONTROL AND FORENSIC PATHOLOGY
SFN 54191 (2-2024)

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).
☐**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 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 the completed form and the documents to the regional Ryan White coordinator or mail/fax to:
Address: Ryan White Program; 600 E Boulevard Ave, Dept. 325; Bismarck, ND 58505-0250.
Secure fax: 701-328-0338; Telephone: 701-328-2378 or 800-471-2180; Website: hhs.nd.gov/HIV/RyanWhite

## Ryan White Program Information

| Ryan White Agency | RW Number | ADAP Number | ☐Enrollment ☐ Re-enrollment |
|---|---|---|---|

## Applicant Information

| | | | | |
|---|---|---|---|---|
| First Name | Last Name | Social Security Number | | |
| Street Address | | 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: | | Preferred Pronouns | | |
| 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 the 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 | | | | |

## Health Coverage (select all that apply and provide a copy of the insurance card, both sides)

| Private Insurance | Medicaid/Medicare | Other |
|---|---|---|
| ☐Employer-based<br>☐Private individual (Marketplace)<br>☐ Private individual off-Marketplace (e.g. COBRA)<br>☐Dental<br>☐Vision<br>☐Other: | ☐Traditional Medicaid<br>☐Medicaid Expansion<br><br>☐Medicare Part A/B<br>☐Medicare Part D (drug coverage)<br>☐Medicare Part C (Medicare Advantage)<br>☐Medicare Supplemental (Medigap) | ☐VA<br>☐IHS<br>☐Other:<br><br>Has your health coverage changed in the past 12 months?<br>☐Yes ☐No ☐ Not sure |
| Insurance Provider's Name (e.g. BCBS) | Member ID | Policy Start Date |
| Insurance Provider's Name (e.g. BCBS) | Member ID | Policy Start Date |
| Are your monthly premiums paid by RW?<br>☐Yes ☐No ☐Not sure | If Yes, list those policies (e.g. Marketplace insurance, Medicare Part D) | |
| **☐ I do not have health coverage as of (date):** | | |

## Health Coverage Screening and Attestation (Complete ONLY if you are uninsured or if you are enrolled in a Marketplace plan where the ND Ryan White program pays your portion of the monthly insurance premium)

**☐My income for the past 12 months was below $20,000.** In the past 6 months, I have:
☐Applied for ND Medicaid and was due to my: ☐Income ☐Citizenship status ☐Having an 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.
☐Other:
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 a Private Employer-Based Plan, you are not in compliance with Ryan White Part B policies 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 a Private Employer-Based Plan, 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 the 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 a 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 the homeless, staying with friends or family)
☐Unstable (emergency shelter, vehicle, streets, hotel, or motel paid for by the emergency funding)
☐Incarcerated (jail or another correctional agency excluding prison)

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 yourself, your spouse, and any other household members (e.g., biological/adopted/stepchildren) that you claim as dependents 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 individual peer support
☐Medications (ADAP)
☐Insurance premiums (ADAP)
☐Vision care
☐Nutritional supplements
☐Transportation
☐HIV support groups

Other

## Basic Needs Assessment

| Please select areas where you need referrals and assistance. | |
|---|---|
| ☐Housing/utilities | ☐Citizenship/immigration status |
| ☐Medical bills | ☐Language/cultural barriers |
| ☐Food and clothing | ☐Legal/incarceration issues |
| ☐Paying bills/money management | ☐Finding/keeping a job |
| Other | |

## Retention in Care and HIV Risk Assessment

| | |
|---|---|
| When was your last visit with your HIV provider?<br>☐Within 6 months ☐Within 12 months ☐ Longer than 12 months | |
| Are you currently virally suppressed?<br>☐Yes ☐ No ☐I do not know | Is your CD4 count above 200 cells/mL?<br>☐Yes ☐No ☐I do not know |
| What HIV medications are you currently taking? | Have you missed any doses in the past 12 months?<br>☐No ☐Yes, describe: |
| Have you had unprotected sex, multiple/anonymous sex partners, or shared needles with anyone in the past 12 months? ☐No ☐Decline to answer ☐Yes, please describe: | |
| Were you ever counseled on HIV PrEP prior to your diagnosis?<br>☐Yes ☐No ☐HIV PrEP was not available (diagnosed before 2012) | |
| Have you ever taken HIV PrEP prior to your diagnosis?<br>☐Yes ☐No ☐Not applicable (Diagnosed before 2012) | Comments |

## Recommended Screenings for Persons Living with HIV

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

## Substance Use and Mental Health Assessment

| | | |
|---|---|---|
| Are you a tobacco user?<br>☐Yes ☐No ☐Former | Are you interested in quitting at this time?<br>☐Yes ☐No ☐Not Applicable | Are you exposed to second-hand smoke? ☐Yes ☐No |
| Do you currently misuse drugs or alcohol?<br>☐Yes ☐No ☐Former use | If yes, check all that apply<br>☐Alcohol ☐Street ☐Prescription ☐Injecting | |
| Would you like a referral?<br>☐Substance Abuse Counseling ☐Syringe Services ☐Tobacco Cessation ☐No ☐Not Applicable | | |
| Comments | | |
| Do you have mental health concerns?<br>☐Yes ☐No ☐Former | Comments | |
| Do you have a history of trauma in your life?<br>☐Yes ☐No | Do you have physical or emotional abuse concerns?<br>☐Yes ☐No, I feel safe | |
| Are you receiving counseling/treatment?<br>☐Yes ☐No ☐Not Applicable | Are you interested in getting help?<br>☐Yes ☐No ☐Not Applicable | |

## 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 |
|---|---|---|---|---|
| **Medical Case Management** | | | | |
| **Linkage and Retention in Medical Care**<br>***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:<br>☐newly diagnosed<br>☐pregnant<br>☐immunocompromised<br>☐released from a correctional facility within the past 90 days<br>☐is/was hospitalized or used ER in the last 30 days |
| **Understanding of HIV & Risk Behavior**<br>***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**<br>***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.<br>Needs adherence counseling. |
| **Health Coverage**<br>***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.<br>☐Not eligible for public or private coverage.<br>☐Eligible but not enrolled. |
| **Non-Medical Case Management** | | | | |
| **Basic Needs**<br>***Acuity Score:*** | ☐Food, clothing, and other basic items available through client's own means.<br>☐Has ongoing access to assistance programs that maintain basic needs consistently.<br>☐Able to perform activities of daily living independently (ADL) | ☐Basic needs met on a regular basis with occasional need for help accessing assistance programs.<br>☐Unable to routinely meet basic needs without emergency assistance.<br>☐Needs assistance to perform some ADL weekly. | ☐Routinely needs help accessing assistance programs for basic needs.<br>☐History of difficulties in accessing assistance programs.<br>☐Often w/o food, clothing, or other basic needs.<br>☐Needs in-home ADL assistance. | ☐Has no access to food.<br>☐Without most basic needs.<br>☐Unable to perform most ADL.<br>☐No home to receive assistance with ADL. |
| **Mental Health** | ☐No history of mental health | ☐Past problems and/or reports current | ☐Having trouble in day-to-day | ☐Danger to self or others and needs immediate |

| Life Area & Score | 0 points Self Mgmt. | 1 point Basic Need | 2 points Moderate Need | 3 points High Need |
|---|---|---|---|---|
| ***Acuity Score:*** | problems. No need for referral. | difficulties/stress – is functioning or already engaged in mental health care. | functioning. Requires significant support. Needs referral to mental health care. | 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**<br>0 pts: Self-Management<br>11-20 pts: Moderate Case Management | 1-10 pts: Basic Case Management<br>21-30 pts: Intensive Case Management | | |
| Notes | | | | |

## Counseling and Referrals Provided (for case managers)

| Referral to HIV medical care<br>☐Yes ☐No ☐Not Applicable | Referral to health coverage enrollment services<br>☐Yes ☐No ☐Not Applicable |
|---|---|
| HIV risk reduction counseling provided<br>☐Yes ☐No ☐Not Applicable | Medication adherence counseling provided<br>☐Yes ☐No ☐Not Applicable |
| Referral to substance abuse services<br>☐Yes ☐No ☐Not Applicable | Referral to mental health services<br>☐Yes ☐No ☐Not Applicable |
| Referral to social services<br>☐Yes ☐No ☐Not Applicable | Referral to housing services<br>☐Yes ☐No ☐Not Applicable |
| Notes | |

## 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 Ryan White case management and other services free of discrimination based on race, color, sex/gender, ethnicity, national origin, religion, age, class, sexual orientation, physical and/or mental ability.
- Participate in creating a plan for your care.
- Be informed about services and options available to you.
- Reach an agreement with your Ryan White case manager about the frequency of contact you will have, either in person or over the telephone.
- Have your Ryan White 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 your care.
- Let your Ryan White case manager know any concerns you have about your care plan or changes in your needs.
- Make and keep appointments to the best of your ability, or if possible, call to cancel or change an appointment time.
- Stay in communication with your Ryan White case manager by informing them of changes in your address, phone number, or income, and respond to their calls or letters to the best of your ability.
- Provide your Ryan White case manager with any requests for payment of bills within **30 days of the statement date** and provide the required documentation.
- Follow the Ryan White case manager's directions to get assistance from other available programs and services.
- Stay in care by visiting your doctor regularly and taking prescribed medication to ensure your health and well-being.
- Annually complete the re-enrollment documentation by **April 30th** for continued Ryan White program eligibility.

## 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 12 months and reporting changes in income, insurance status, or residency to my case manager.

☐I understand that I must **re-enroll each year by April 30th 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 |

## 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 | Other medical care providers (pharmacist, dentist, etc.) |
| County human service worker | ND Medicaid representative |
| Insurance enrollment assisters | Insurance providers |
| Ryan White program staff | Housing assistance coordinator |
| Social workers | Peer navigators or advocates |
| Other: | |

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 the 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 |