Ryan White Part A
Registration Letter

Thank you for your recent registration and interest in receiving Ryan White Part A services. The Ryan White Part A HIV/AIDS Program is a federal program that addresses the unmet health needs of persons living with HIV/AIDS (PLWH/A) by funding primary health care and support services that enhance access to and retention in care.

The eligibility process for this program begins today, _____. Your eligibility begin date is _____ and your eligibility end date is _____. It is your responsibility to schedule an appointment by _____ for you eligibility redetermination.

If you have any questions about your eligibility approval, please contact:

_____ at _____

Agency Name/Phone Number

It is important to stay connected. Please report any changes to your registering agency. These changes may include your address, telephone number, financial needs, living arrangements, services needs or physicians name. Thank you again for your interest in Ryan White Part A services.

_____ _____

Client's Signature **Date**

_____ _____

Parent or Guardian **Date**

_____ _____

Registering Agency Staff Member **Date**

Las Vegas TGA Ryan White Part A HIV/AIDS Program

Ryan White Part A
Eligibility Documents

Name: _____ URN: _____ Date: _____
Phone: _____ Eligibility Specialist Reviewing: _____

Documentation from each category must be attached to this document and easily located in the client file for each initial registration and six month reassessment on all Part A clients.

	Proof of Identification (Photo ID Required)
	Nevada or Arizona Exp Date : _____
	Passport/Foreign Country ID Exp Date: _____
	INS papers/Permanent Resident Card
	Social Security Card (in conjunction with picture ID)
	Government issued ID Card
	Baptismal Certificate
	Birth Certificates of children in household
	Birth Certificate (in conjunction with picture ID)
	Other: _____

	Proof of Diagnosis (Required for newly registered clients only
	Western Blot
	Quantitative Viral Load
	Physicians Letter on letterhead signed by M.D. with at least one (1) of these items:
	a. Indication client is receiving treatment for HIV/AIDS
	b. Statement of quantitative viral load

	Proof of Residency (2 forms required)
	Lease Agreement
	Rent/Mortgage Receipt
	Utility Bill
	Statement of Living Arrangements
	Letter from a Government Agency
	Voter Registration/Vehicle Registration
	Prison Release Papers
	Other: _____

Date: _____

Clients Signature: _____

	Proof of Income (Submit at least one dated within the last 90 days)
	Pay stubs for the most recent 90 day period
	Social Security Statement (most recent)
	VA Benefits
	Recent Tax Return
	Statement of no income
	Statement of unemployment benefits
	Statement of child support
	Statement of cash assistance
	Bank statements with direct deposits
	Pension statement
	Statement of support from family/friend
	Other: _____

	Medical Insurance
	Medicare/Medicaid
	Statement of Cobra Insurance
	CCSS Medical Card
	VA Card
	Private Insurance
	AHCCS Card (Arizona Residents)
	Pending
	SSI/SSD/Medicaid

	Asset Verification
	Bank Statement (last month's statement)
	Vehicle registration
	Statement of retirement funds
	Life insurance policy (with cash value)
	Tax refunds
	Lump sum awards for the last 12 months (excluding S.S. lump sums or IRS refunds)
	Real estate holdings
	Proof of asset spend down (receipts)

Las Vegas TGA Ryan White Part A HIV/AIDS Program

Ryan White Part A
Client Registration Form

Today's Date:	Client URN:	Does the client need an interpreter: ☐ Yes ☐ No If so, what language:
☐ Newly Diagnosed or New to Care ☐ Returning Client (out of care for 12 months or more)		Assigned Case Manager:

DEMOGRAPHICS

Last Name:	First Name:	Middle Name:

Gender:	Ethnicity:	Race:	Marital Status:
☐ Male ☐ Female ☐ Transgender (male to female) ☐ Transgender (female to male) ☐ Transgender (Unk) ☐ Unknown	☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino ☐ Unknown/Unreported	☐ Asian ☐ White ☐ Black or African American ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaskan Native ☐ Multi-Racial ☐ Other ☐ Unknown	☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partner

Date of Birth: / / (☐ check if estimated)	Age:	Social Security Number:

Home Address: Apt #	City:

State:	County:	Zip Code:

☐ check if same as home address Mailing Address: Apt #	City:

State:	County:	Zip Code:

May we contact you by mail at this address? ☐ Yes, contact via mailing address ☐ No

Home phone#: ( )	Other phone#: ( )

May we leave you a message at this phone number? ☐ Yes, contact via home phone # ☐ Yes, contact via other phone # ☐ No

Have you ever served in the military? ☐ Yes ☐ No If yes, please list your dates of services: _____ to _____

What is your primary source of transportation: ☐ Own a car ☐ Public Transportation (bus) ☐ Friends/relatives ☐ Walking ☐ Other: _____

HIV/AIDS STATUS AND MEDICAL INFORMATION

What is your HIV/AIDS status:	How were you infected with HIV/AIDS:
☐ HIV-positive (not yet AIDS) ☐ HIV-positive (AIDS status unknown) ☐ AIDS ☐ HIV-negative (affected) ☐ Unknown ☐ HIV-indeterminate (only if under 2 years of age)	☐ Male to Male sexual contact ☐ Injection Drug Use ☐ Hemophilia/Coagulation Disorder ☐ Heterosexual Contact ☐ Perinatal Transmission ☐ Undetermined/Unknown, risk not reported or identified ☐ Recipient of transfusion of blood, blood components, or tissue ☐ Other, please specify:_____

HIV Diagnosis Date: (☐ check if estimated)	AIDS Diagnosis Date: (☐ check if estimated)

Who is your Primary HIV Medical Provider or where do you go for HIV medical care:

Location name:

Results of your most recent Viral Load:	What is the date of that Viral Load:

Results of your most recent CD4 Count:	What is the date of that CD4 Count:
Are you currently taking any prescribed medications? ☐Yes ☐No ☐Sometimes If so, what medications are you taking:	

Who is your primary insurance provider:	Other Insurance (if any):
☐Medicaid/AHCCCS ☐Medicare ☐No Insurance ☐Other, please specify:_____ ☐Other public (e.g. Champus, VA) ☐Private Insurance ☐Unknown	☐Medicaid/AHCCCS ☐Medicare ☐No Insurance ☐Other, please specify:_____ ☐Other public (e.g. Champus, VA) ☐Private Insurance ☐Unknown

EMERGENCY CONTACT INFORMATION			
Contact name:	Relationship to you:		
Address:	City:	State:	Zip Code:
Home phone#: ( )	Other phone#: ( )	Is this contact aware of your diagnosis? ☐Yes ☐No	

EMPLOYMENT AND ASSET INFORMATION
What is your current occupation:
Who is your current employer:
Do you have any assets (savings, CD, cash, ect.)? ☐Yes ☐No
If so, what is the total amount of those assets? $
Do you own a home or other property? ☐Yes ☐No
Do you own more than one registered vehicle? ☐Yes ☐No

CURRENT SERVICE NEEDS	
What services are you in need of today, (please check all that apply):	
☐Housing Assistance	☐Employment Assistance
☐Emergency Financial Assistance	☐Food Bank
☐Support Groups	☐HIV/AIDS Information
☐Individual Counseling	☐Vision Care
☐Nutrition Therapy	☐Transportation Assistance
☐HIV/AIDS Medical Provider	☐Substance Use Treatment/Counseling
☐HIV/AIDS Medication	☐Mental Health Treatment/Counseling
☐Assistance with Medication Co-Pays	☐Eligibility for Ryan White Services
☐Other:	

INCOME INFORMATION	
List below all income you and those living in your household-including spouses, domestic partners and any dependents that could be claimed on your taxes-receive from the following sources on a monthly basis:	
Alimony	$
Child Support	$
Wages from Employment	$
Food Stamps	$
State Disability Insurance/SDI	$
Long-Term Disability/LTD	$
VA Benefits	$
Supplemental Security Income/SSI	$
Social Security Disability Income/SSDI	$
Social Security Retirement	$
TANF	$
Retirement	$
Gifts	$
Other (specify):	$
Total Monthly Household Income	$
Total Annual Household Income	$

LIVING STATUS AND RELATIONSHIP INFORMATION	
What is your current living /housing arrangement: ☐ Stable/Permanent ☐ Unstable ☐ Other:_____ ☐ Institution ☐ Non-permanently housed	How many people live with you: Please list everyone who lives with you in the provided space below.

Name	*Relationship to you*	*Gender*	*Date of birth*
			(☐ check if estimated)
			(☐ check if estimated)
			(☐ check if estimated)
			(☐ check if estimated)
			(☐ check if estimated)
			(☐ check if estimated)
			(☐ check if estimated)

ADDITIONAL REFERRALS Please list any additional referrals (not listed above) provided to the client for Ryan White or non-Ryan White Community Resources.	
Service Needed:	Organization Referred to:

CASE MANAGEMENT NOTES If documented in CAREWare or another location please specify.	
☐ Client agrees to participate in Case Management Services. ☐ Client elects not to participate in the program at this time. ☐ Client is not eligible for Ryan White Part A and will be referred to resources they are eligible for. Today's Date: _____ Case Managers Signature: _____ Next Eligibility Redetermination Date: _____	The Case Management Program has been explained to me and any questions I had have been answered. I agree to participate in Case Management Services. Today's Date: _____ Clients Signature: _____ Parent or Guardian Signature: _____

Las Vegas TGA Ryan White Part A HIV/AIDS Program

Ryan White Part A Medical Case Management Screening Tool

Please attach to client registration or reassessment form

Today's Date:	Client URN:	Assigned Case Manager:
Last Name:	First Name:	Middle Name:

HIV/AIDS MEDICAL APPOINTMENT ADHERENCE SCREENING

1. Does the client have an HIV/AIDS Medical Provider? ☐ Yes ☐ No (provide referral) ☐ Just entering the care system (provide referral)

2. Date of last medical appointment? _____ Date of next medical appointment? _____

3. Does the client have a copy of current labs (maximum of 6 months from today's date)? ☐ Yes ☐ No

4. Please check all of the barriers to medical care that the client mentions:

☐ Just entering the care system	☐ Not ready to access care	☐ Afraid
☐ Homelessness	☐ Doesn't want to deal with it	☐ Feels fine/no symptoms
☐ Doesn't know where to go	☐ Couldn't get an appointment	☐ Drugs/Alcohol in the way
☐ Doesn't think it will help	☐ Clinic hours aren't convenient	☐ Child care unavailable
☐ Don't want people to know	☐ Doesn't like the doctors there	☐ No transportation
☐ Language barriers	☐ Lack of proper identification	☐ Other, please specify:

Please assess and work with clients to diminish barriers to care.

Referral provided for medical care? ☐ Yes ☐ No ☐ Client Refused

If yes, where: _____

Clients must be referred for medical care if they do not currently have a medical provider or if they don't have current labs (dated no more than 6 months prior to the current appointment).

Notes:

HIV/AIDS MEDICATION ADHERENCE SCREENING

1. Is the client currently prescribed HIV/AIDS medication? ☐ Yes ☐ No

2. Does the client currently take their medication? ☐ Yes ☐ No ☐ Sometimes

3. How many doses has the client missed in the last month? ☐ 0 ☐ 1 ☐ 2 or more

If client reports missing doses please ask them why, (check all that apply):

☐ Doesn't want to deal with it/take meds	☐ Lack of social support	☐ Alcohol and/or Drug Use/Abuse
☐ Side effects	☐ Doesn't think meds work	☐ Medication regimen too complex
☐ Depression/Mental Health issues	☐ Can't get refills in time	☐ Alcohol and/or Drug Use/Abuse
☐ Too many pills	☐ Taste of medication	☐ Other:

Please assess and work with clients to diminish barriers to care.

Counseling provided or referral provided for Medication Adherence Counseling? ☐ Yes ☐ No ☐ Client Refused

If yes, where : _____

Notes:

NUTRITION SCREENING

1. What is your current weight and height? _____ feet _____ inches _____ weight

2. Without wanting to, have you experienced significant weight loss in the last 6 months? ☐ Yes ☐ No

3. Are you being treated for medical issues in addition to HIV, such as; diabetes, kidney disease, liver disease/hepatitis, high cholesterol/heart disease, hypertension, cancer, anemia, depression? ☐ Yes ☐ No ☐ Other: _____

4. Are you experiencing any extreme side effects from your medication such as vomiting, diarrhea or poor appetite (little or no desire to eat)? ☐ Yes ☐ No

5. Do you have access to food? ☐ Yes ☐ No

Referral provided for Medical Nutrition Therapy or other food provider? ☐ Yes ☐ No ☐ Client Refused

If yes, where: _____
Notes:

CAGE SUBSTANCE/ALCOHOL ABUSE SCREENING

Is the client currently in any kind of treatment for substance or alcohol use (includes meeting with a psychologist or counselor, attending group sessions)?
☐ Yes (stop here) ☐ Never used either substance (stop here) ☐ No (complete screening)

1. During the **past month**, have you felt you ought to cut down on your drinking or drug use? ☐ Yes ☐ No

2. During the **past month**, have people annoyed you by criticizing your drinking or drug use? ☐ Yes ☐ No

3. During the **past month**, have you felt bad or guilty about your drinking or drug use? ☐ Yes ☐ No

4. During the **past month**, have you had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hang-over-eye-opener? ☐ Yes ☐ No

If the client answered "yes" to any of the above substance abuse screening questions a referral for substance abuse treatment is strongly encouraged.
Referral provided for Substance or Alcohol abuse? ☐ Yes ☐ No ☐ Client Refused

If yes, where: _____
Notes:

EVALUATION OF MENTAL HEALTH DISORDERS SCREENING TOOL
Questions taken from the Primary Care Evaluation of Mental Disorders Screening Tool

Is the client currently being treated for a mental health problem (includes professional help from psychologist or counselor, attending group therapy sessions taking medication for depression or anxiety)?
☐ Yes (stop here) ☐ No (complete screening)

1. During the **past month**, have you been hearing or seeing things that other people don't seem to hear or see? ☐ Yes ☐ No

2. During the **past month**, have you been bothered by feeling down, depressed, or hopeless? ☐ Yes ☐ No

3. During the **past month**, have you been bothered by little interest or pleasure in doing things? ☐ Yes ☐ No

If the client answered "yes" to any of the mental health screening questions a referral for further screening by a mental health professional is strongly encouraged.

Referral provided for Mental Health Treatment? ☐ Yes ☐ No ☐ Client Refused

If yes, where: _____
Notes:

Las Vegas TGA Ryan White Part A HIV/AIDS Program

Ryan White Part A
Client Acuity Tool

Client Name:			**Today's Date:**	
Barriers	**Level 0-1** "0"-no intervention needed. "1"-short term, focused, education/support/referrals.	**Level 2** "2" multiple barriers, provide education/support.	**Level 3** "3"-Multiple, complicated barriers, and/or is in crisis.	**Level**
Housing	Stable, clean housing.	Requires short term assistance with/rent, utilities.	Homeless, shelter resident, or frequent moves.	
Finances	Steady, adequate source of income.	Income source is inconsistent or too low to meet basic needs.	Has no income. Is in financial crisis. Consistently unable to meet basic needs.	
Transportation Issues	Has own transportation to get to and from clinic visits.	Some difficulties with access to transportation.	Consistent problems with accessing transportation.	
Social Support/Family Issues	Dependable network/family/friends/partner.	Gaps in support system (family/friends periodically) Pregnant but adherent.	No stable support other than professionals. Family in crisis. Pregnant but not adherent. Fear of disclosure.	
Behavior	Functions appropriately in most settings.	Repeated incidences of inappropriate behavior.	Abuse or threats to others; lack of control.	
Communication Issues	Speak, read and understand English at an adult level.	Some difficulties with speaking, reading and understanding English.	Not able to represent themselves in English. Unable to read or write.	
Cultural Issues	Minimal system barriers	Requires some assistance acclimating to system.	Chooses not to/unable to acclimate to system.	
System Issues	Minimal system barriers.	Needs help accessing the system.	Distrust of system/not accessing services.	
Legal Issues	Client reports no recent or current legal problems; all pertinent legal documents completed.	Needs assistance completing standard legal documents; recent or current legal problems.	Involved in civil or criminal matters; incarcerated or recently incarcerated; undocumented immigrant; unaware of standard documents, i.e. living will.	
Mental Health Issues	No current mental health illness but has a history of mental illness, now stable.	Mild to moderate symptoms or disorders.	Severe symptoms/disorders; long history of mental disorders.	
Substance Use/Abuse	No current use and/or history.	History of abuse and/or intermittent abuse.	Chaotic life, regular substance abuse.	
Side Effects	On medication, having no side effects.	Minimal side effects affecting some quality of life.	Moderate to severe side effects affecting quality of life.	
Adherence History	Reports ability or willingness to adhere to medications.	Reports inconsistent ability to adhere to medications.	Reports inability to adhere to medications. Treatment naïve.	
Educational Issues	Has been informed, able to verbalize basic knowledge of the disease.	Some understanding of the disease.	No understanding of HIV disease. New diagnosis. <18 years of age.	
Medical Needs	Stable health; goes for periodic MD appointments and lab monitoring.	Needs primary care referral. Being seen by MD for short term illness.	Poor health; medical emergency; rapidly deteriorating; with opportunistic infections. Pregnant.	
Comments Section:			**Combined Total**	

Client Level Acuity Guidelines:

Acuity Level	***Range***	***Case Management Level***	***Referral Criteria***
Life Area 0-1	15 Points or Less	Medical or Non-Medical Case Management	Self referral as needed
Life Area 1 & 2	16-30 Points	Intensive Medical Case Management-Social	Refer to appropriate community partners
Life Area 2 & 3	31 Points or Higher	Intensive Medical Case Management-Medical	Intensive Medical Case Manager to follow

Note: If a client scores a 3 in any life categories of Medical Needs, Educational Issues, or Adherence History, a referral to Intensive Medical Case Management is strongly encouraged. If a client scores a 3 in the life categories of Cultural Issues, Educational Issues, Social Support/Family Issues, Housing or Finances, a referral to Moderate Medical Case Management is strongly encouraged.

Las Vegas TGA Ryan White Part A
HIV AIDS Program

Ryan White Part A
Statement of Consumer Rights

The following statements reflect the rights and responsibilities of individuals with HIV-disease seeking **Ryan White Part A** funded care and support services within the Las Vegas Transitional Grant Area.

1. **RESPECT * COURTESY * PRIVACY**
   The consumer has the right to be treated, at all times, with respect and courtesy within a setting that provides the highest degree of privacy possible.

2. **FREEDOM FROM DISCRIMINATION**
   The consumer has the right to freedom from discrimination related to age, ethnicity, national origin, gender, disability, religion, sexual orientation, values and beliefs, marital status, medical condition, or any other arbitrary reasons.

3. **ACCESS TO HIV/AIDS SERVICE INFORMATION**
   The consumer has the right to full access to information from the healthcare providers about current FDA approved or other proven HIV/AIDS treatments. The consumer has the right to full access to information from all service providers about HIV-related social and support services.

4. **IDENTITY AND PROVIDER CREDENTIALS**
   The consumer has the right to know the identities, titles, and affiliations of all health and social service providers, as well as anyone else involved in the consumer's care.

   The consumer has the right to know about health or social service organizational rules and regulations that are pertinent to the care or type of care a client receives.

5. **CULTURALLY SENSITIVE SHARING OF INFORMATION**
   The consumer has the right to have information shared in a way that is easily understood and sensitive to each consumer's background, culture, and ethnicity.

6. **CONSENT AND CARE PLAN**
   The consumer has the right to be involved in and make decisions about their plan of care prior to the start of and during the course of treatment. Consumers have the right to renegotiate the care plan at any time.
   The consumer has the right to give informed consent before undergoing any healthcare procedure or receiving any social service. The consumer may change his or her mind after refusing or consenting to services without affecting ongoing care

7. **SELF DETERMINATION**
   The consumer has the right to access all available services pending eligibility.

8. **DECLINING SERVICES**
   The consumer has the right to refuse to participate in any care/service plan. Such refusal may affect eligibility. The consumer may change his or her mind regarding any service without affecting ongoing care.

9. **NAMING AN ADVOCATE**
   The consumer has the right to identify an advocate such as a family member or other person to support the consumer by notifying the relevant service provider.

10. **ADVANCE DIRECTIVES**
    The consumer has the right to have advance directives, such as a Living Will, Healthcare Proxy or Durable Power of Attorney for health and social services.

11. **ACCESS TO FINANCIAL INFORMATION**
    The consumer has the right to inspect and receive an explanation of healthcare bills or proposed changes, regardless of payment sources. The consumer has the right to receive needed referral and support with payment problems.

12. **CONSUMER GRIEVANCE PROCEDURE**
    The consumer has the right to file a written grievance without fear of pressure, retaliation, or interruption of services.
    The consumer has the right to receive a written response to a grievance in a timely manner.

13. **CONSUMER SATISFACTION**
    The consumer has the right to express his or her satisfaction or dissatisfaction with any Ryan White Part A Service Provider.

14. **CONFIDENTIALITY * ACCESS TO RECORDS**
    The consumer has the right to confidentiality and access to treatment records and communications related to his or her case.

15. **OPEN DISCUSSION**
    The consumer has the right to open and honest discussion in all dealings with health or social service providers.

16. **CONTINUITY OF CARE AND TRANSFER**
    When a transfer for care/service for any reason is needed, the consumer shall be informed of all possible options.
    A provider may not initiate transfer of the consumer's case to another provider or facility unless a complete explanation of the need for the transfer and alternatives to transfer are provided to the consumer. The new provider or facility must be notified of the transfer.

17. **TERMINATION OF ELIGIBILITY**
    The consumer has the right to receive timely notification of program changes affecting eligibility.
    If deemed ineligible, the consumer has the right to pursue the Ryan White Part A eligibility appeals process.

I have received, reviewed, and understand the Statement of Consumer Rights:

Printed Name of Client	**Client URN#**
Client's Signature	**Date**
(If Applicable) Parent or Guardian	**Date**
Care Coordinator	**Date**

This client is judged unable to understand his/her consumer rights; therefore, I exercise the patient's rights.

Care Coordinator or Parent/Guardian	**Date**

Ryan White Part A
Grievance Procedure

The grievance procedure for Ryan White Client Care Services is as follows:

If your complaint is related to a problem you encountered while accessing services at one of the participating provider agencies, please bring your complaint/grievance to the attention of the appropriate person at that agency and follow the grievance procedure. Each agency has a grievance form available.

Upon your request you will be provided with:

- An agency grievance form in triplicate
- A pre-addressed and pre-stamped envelope addressed to the agency's executive director
- A pre-addressed and pre-stamped envelope addressed to the Las Vegas Part A Grants Administrator

After receipt of your written complaint/grievance, you will be contacted by the Ryan White Part A Grantee to discuss your concerns.

I have reviewed the above Grievance Procedure and have been offered a copy of the same:

_____	_____
Client's Signature	**Date**
_____	_____
Parent or Guardian	**Date**
_____	_____
Ryan White Part A Representative	**Date**

Ryan White Part A
Grievance Form

Today's date: _____

Client name: _____

Client phone number: _____

Date of incident: _____

Agency name this grievance is regarding: _____

Please use the space provided to give a detailed description of your complaint/issue and any related information. Additional pages may be used if needed. After receipt of your written complaint/grievance, you will be contacted by _____ to discuss your concerns.

_____
_____
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_____
_____

I hereby certify that the information provided above is true to the best of my knowledge.

_____
Client Signature

Las Vegas Transitional Grant Area
Ryan White Care Services

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
RECONOCIMIENTO DE RECIBO DE LA NOTICIA DE PRACTICAS PRIVADAS

I HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES:
YO HE RECIBIDO UNA COPIA DE LA NOTICIA DE PRACTICAS PRIVADAS DE ESTA OFICINA:

_____
Please print name (Escriba su nombre, por favor)

_____
Signature (firma)

_____
Date (fecha)

FOR OFFICE USE ONLY (PARA USO DE OFICINA SOLAMENTE)

A written acknowledgement of Receipt of our Notice of Privacy Practices was attempted; however acknowledgement could not be obtained because:

Individual refused to sign_____

Communication barriers prohibited obtaining the acknowledgement_____

An emergency situation prevented us from obtaining acknowledgement_____

Other: _____
_____
_____

Las Vegas TGA Ryan White Part A HIV/AIDS Program

Ryan White Part A
Consent for Release of Confidential Information

Client's Name: _____

Date of Birth: _____ URN: _____

I, the undersigned, do hereby authorize any of the agenices listed below who participate in the community-based Ryan White Care Services program in the Las Vegas Tgansitional Grant Area (TGA) to release and/or share information concerning my eligibility, medical record status, and information concerning my HIV screening, diagnosis and treatment. The following agencies/programs authorized are:

- Access to Healthcare
- Aid for AIDS of Nevada (AFAN)
- Community Counseling Center
- Community Outreach Medical Center
- Clark County Social Services
- Golden Rainbow
- Mohave County Health Department
- Nye County Health & Human Services
- Southern Nevada Health District
- University Medical Center-Wellness Center
- Your Physician:_____

Information may be released between the above listed agencies throughout the duration of my active enrollment in the Ryan White Care Services program. I may withdraw this consent by notifying, in writing, the Ryan White Part A agency where my eligibility was completed. I understand that my records are protected under federal HIPAA regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I may revoke this consent in writing any time, except to the extent that any action has been taken while it is still in force. This consent expires automatically one (1) year from registration or previously signed consent.

A copy of this authorization legally constitutes an original copy.

_____ _____
Client's Signature Date

_____ _____
Parent or Guardian/ Relationship to Client Date

_____ _____
Witness Date

Las Vegas TGA Ryan White Part A HIV/AIDS Program

Ryan White Part A
Affected Client Consent for Release of Confidential Information

Affected Client's Name: _____

Date of Birth: _____ **URN:** _____

I, the undersigned, do hereby authorize any of the agenices listed below who participate in the community-based Ryan White Care Services program in the Las Vegas Tgansitional Grant Area (TGA) to release and/or share information concerning my eligibility, medical record status, and information concerning my HIV screening, diagnosis and treatment. The following agencies/programs authorized are:

- Access to Healthcare
- Aid for AIDS of Nevada (AFAN)
- Community Counseling Center
- Community Outreach Medical Center
- Clark County Social Services
- Golden Rainbow
- Mohave County Health Department
- Nye County Health & Human Services
- Southern Nevada Health District
- University Medical Center-Wellness Center

Information may be released between the above listed agencies throughout the duration of my active enrollment in the Ryan White Care Services program. I may withdraw this consent by notifying, in writing, the Ryan White Part A agency where my eligibility was completed. I understand that my records are protected under federal HIPAA regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I may revoke this consent in writing any time, except to the extent that any action has been taken while it is still in force. This consent expires automatically one (1) year from registration or previously signed consent.

A copy of this authorization legally constitutes an original copy.

_____ _____
Affected Client's Signature (Required for persons over 18) Date

_____ _____
Client Signature Date

_____ _____
Parent or Guardian/ Relationship to Client Date

_____ _____
Witness Date

I understand that, by signing this release, I am allowing _____ to seek
Affected Client's Name

services and discuss issues concerning my service related information only, to assist in my

-_____-care. I also understand that I may revoke this consent in writing at any time.
Client's Name

I am withdrawing this consent for release of information.

_____ _____
Signature of Client **Date**

_____ _____
Relationship **Date**

Ryan White Part A
Homeless Declaration Form

Today's Date: _____

Client name: _____

Client URN: _____

I declare that I meet one of the following conditions of homelessness to fulfill the Ryan White Part A eligibility requirement for residency.

- ☐ Live in a motel, hotel or weekly rate housing
- ☐ Live in a shelter (family, domestic violence, youth shelter, or transitional living program).
- ☐ Live in an abandoned building, in a car, campground, or on the street
- ☐ Other: _____

Last known address:
_____

General area and zip code of where the client resides:
_____

I hereby declare that the above information regarding my current living situation is true.

_____
Client's Signature

_____
Date

Residence Verification Form

Today's date: _____

I, _____,
Client name

currently reside at
_____.
Current address (no P.O. Boxes allowed)

My monthly rent is $_____.

I hereby declare that the above information regarding my current living situation is true.

_____ _____
Client's Signature **Date**

I hereby declare that the above information regarding my tenants living situation is true.

_____ _____
Landlord name (please print) **Landlord signature**

_____
Date

Ryan White Part A
Verification of No Income

I, _____, have requested services from Ryan White
Client's Name
Part A which requires verification of all income. I have stated during this

verification that I have no income at this time.

I have not received income since _____.

I do not expect to receive income until _____.

I have applied for DDS or SSI on _____.

I understand that the above information is true and correct and understand that willfully giving false information will disqualify me from services and may result in legal/criminal action.

I further agree that if my financial status changes, I must immediately notify the Ryan White Part A eligibility agency and provide documentation of income.

_____ _____
Client's Signature **Date**

_____ _____
Parent or Guardian **Date**

_____ _____
Registering Agency Staff Member **Date**

_____ _____
Client Name **Client URN#**

Verification of No Health Insurance Form

Client Section:
Today's date: _____

I, _____,
Client Name

am currently employed full time or part time (please circle one)

at_____.
Name and Address of Employer

Employer Section:
I hereby declare that _____ is currently NOT eligible and WILL NOT
Client's Name
be eligible in the next six months to enroll in a private health insurance benefits plan

through their employer.

_____
Employer's name (please print)

_____
Phone number

_____
Employer's signature

_____
Date

Today's Date: / /	Client Name:

Goal #1:

Case Manager's Tasks	Client's Tasks	Progress Note

Goal #2:

Case Manager's Tasks	Client's Tasks	Progress Note

Goal #3:

Case Manager's Tasks	Client's Tasks	Progress Note

Conditions for Assistance: Client will notify case management staff if there is ANY change in income or benefits and provide needed documentation. Client will also notify agency if there is a change in the number of persons in the household or a change in address or phone number.

Case Management Staff Contact Information:

Signing below indicates that you have read, understand and will comply with the case management care plan and terms above. This also indicates that you have received a copy of your case management care plan.

Client's Signature:	Date:
Case Manager's Signature:	Date:

A copy of the completed (signed and dated) form must be given to the client in addition to a copy kept in the client chart.