Mississippi Ryan White Part B Comprehensive Eligibility Application

Date: _____ **Applicant Signature:** _____

APPLICANT INFORMATION

Last	**First**	**MI**
Birth date (month/day/year)	**AKA (also known by these other names)**	

Gender
☐ Male ☐ Transgender -Male to female
☐ Female ☐ Transgender -Female to male

Sex At Birth ☐ Male ☐ Female

Ethnicity
☐ Hispanic
☐ Non-Hispanic

Race (choose all that apply)
☐ White ☐ Black or African American ☐ Asian
☐ Native Hawaiian/Other Pacific Islander
☐ American Indian/Alaska Native
☐ Other: _____

Language Preference
English ☐ Spanish ☐ Other ☐ _____

Social Security Number (SSN) or Alien ID if no SSN.*

Primary Phone # _____
Type: home ☐ cell ☐ work ☐ other ☐
OK to leave messages? Yes ☐ No ☐

Secondary Phone #: _____
Type: home ☐ cell ☐ work ☐ other ☐
OK to leave messages? Yes ☐ No ☐

Email Address

Home Address **Apt/Suite #**	**City**	**State**	**Zip Code**	**OK to mail?** Yes ☐ No ☐
Mailing Address (if different) **Apt/Suite #**	**City**	**State**	**Zip Code**	**OK to mail?** Yes ☐ No ☐

Housing Type: **Stable** ☐ **Temporary** ☐ **Unstable** ☐

Do you live in subsidized housing? **Yes** ☐ **No** ☐

Is half of your income spent on rent and utilities? **Yes** ☐ **No** ☐

Name of Emergency Contact	**Phone Number**	**Aware of Status?** Yes ☐ No ☐

Ryan White Case Manager Name	**Agency**	**Phone Number**	**Case Manager should be contacted instead of client?** Yes ☐ No ☐
Primary Care Provider	**Clinic Name**	**City, State**	**Phone Number**
Specialist Provider	**Clinic Name**	**City, State**	**Phone Number**

DIAGNOSIS INFORMATION (New Applicants Only)

Date of HIV-positive diagnosis:	**Is this date estimated?** Yes ☐ No ☐	**Have you ever been told you have AIDS?** Yes ☐ No ☐	**Date of AIDS diagnosis:**	**Is this date estimated?** Yes ☐ No ☐

Risk/Exposure Category (answer all questions):
Have you ever had sex with a male? Yes ☐ No ☐
Have you ever had sex with a female? Yes ☐ No ☐
Have you ever used injection (IV) drugs? Yes ☐ No ☐
Have you been diagnosed with hemophilia/coagulation disorder? Yes ☐ No ☐

Have you ever received a blood transfusion? Yes ☐ No ☐
Have you ever received an organ transplant? Yes ☐ No ☐
Did you get HIV from your mother? Yes ☐ No ☐
Unknown Yes ☐ No ☐
Other (please explain): _____

Official Use Only:					
☐	**RW Part B DCP**	☐	**ADAP Direct**	☐	**ADAP IAP** **(May select more than one)**
Certified Application Assistor:				**Phone:**	
Date Application Reviewed and Submitted:					

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HIV DIAGNOSIS DOCUMENTATION (New Applicants Only)

New applicants must provide proof of their HIV-positive diagnosis. Please provide one of the documents listed below. Check which one is provided. Attach documents to this application.

☐	Lab report with your full name that shows measurable viral load by bDNA or PCR showing detectable virus level
☐	1) Positive HIV immunoassay AND positive confirmatory test, OR 2) Positive detectable HIV RNA reflecting the current algorithm approved by the Association of Public Health Laboratories (APHL).
☐	A statement signed by a prescribing medical professional on office letterhead or prescription pad indicating that the individual is HIV positive. An authenticated lab report, to confirm HIV status must be provided within 60 days.

***** *SSN information is not used for eligibility determination. It is used to verify income, or Medicaid/Medicare coverage.*

RESIDENCY DOCUMENTS

Please provide **ONE** of the following residency documents issued within the allowable timeframes.

- The document must include the client's name and home address (no P.O. Boxes).
- **Attach copy to this application.**

RESIDENCY DOCUMENTS (check and attach ONE copy of document)	
☐	Income verification (check stubs with physical address, NO P.O. BOX)
☐	Utility bill in the individual's name
☐	Valid Driver's License
☐	ID card issued by State Department of Motor Vehicles
☐	A letter or award from Social Security, food stamps, TANF, VA, or SSI
☐	A postcard/envelope addressed to the individual at his/her stated residence, with that correspondence having a postmark within 30 days from the date he/she is seeking eligibility certification. Note: A Post Office (PO) box alone is NOT an acceptable form by which to establish residency.
☐	For undocumented immigrants, a statement by the case manager and signed by the individual stating that the individual does not have a valid state ID due to his/her undocumented immigration status and does not possess any documents that could otherwise be used to verify residency.
☐	Ryan White Case Manager attestation of home visit or homelessness – dated within 30 days (use the **Attestation** below)
☐	Homeless Services Agency Residency Attestation of homelessness – dated within 30 days (use the **Attestation** below)

Case Manager Residency Attestation

Agency Use Only: May only be completed by a Case Manager or Part B Eligibility Specialist

_____I affirm I have visited the client at the address identified in the client information section.

_____I affirm the client is homeless.

_____ _____

Staff Member Printed Name | Name of Provider Agency

_____ _____

Staff Member Signature | Date

Homeless Services Agency Residency Attestation

Agency Use Only: May only be completed by homeless services agency

_____I affirm the client is homeless.

_____ _____

Representative Printed Name | Name of Provider Agency

_____ _____

Representative Signature | Date

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HEALTH INSURANCE/OTHER PAYER

If you have medical coverage, please attach a copy of your health insurance card and prescription drug card. Please note that you will be required to provide proof of denial for health insurance coverage if it appears you may be eligible.

HEALTH INSURANCE SCREENING

SCHIP- MS Medicaid	Federal Facilitated Marketplace (FFM) Insurance
What is your Medicaid/CHIP Status? ☐ Enrolled ☐ Pending. Date applied ___/ ___/__ ☐ Denied ☐ Not eligible. Please explain: _____	**What is your FFM Status?** ☐ Enrolled ☐ Pending. Date applied __/___ /__ ☐ Denied ☐ Not eligible. Please explain: _____

Medicare

Medicare Status : A☐ B☐ D☐ Advantage Plan☐ ☐ Enrolled; effective date____/___/_____ ☐ Will be eligible in the next 12 months? Date ____/__/____/_____ ☐ Not enrolled now but was in the past ☐ Applicable	**If you are enrolled in Medicare, what is your Extra help/low-income subsidy (LIS) status:** ☐ Enrolled ☐ Pending. Date applied __/___/__ ☐ Denied ☐ Not eligible. Please explain: _____

Employment

Are you currently employed? ☐ **Yes** ☐ **No**	**Are you receiving disability income? ☐Yes ☐No**	**If yes, disability is based on: ☐ HIV ☐ Mental Health ☐Drug/Alcohol ☐Other Medical** _____

Other Governmental Health Insurance Programs

Are you eligible or receive health services from Veteran's Affairs? ☐ Yes ☐ No ☐ I don't know **If you don't know, please call 1-800-827-1000**	**Are you eligible or receive health services from Indian Health Services?** ☐ Yes ☐ No

Private or Employer-Provided Health Insurance

Do you have health insurance: ☐ Yes ☐ No **If yes, who do you get the insurance through?**
☐Private, individual plan ☐My Employer ☐Spouse, Parent or Domestic Partner ☐ COBRA ☐ Other_____

Can you get insurance through:
☐My Employer ☐Spouse, Parent or Domestic Partner ☐ Private, individual plan ☐ COBRA ☐ Not eligible/Not sure

Have you applied for coverage? ☐ Yes ☐ No,
If No, when are you eligible to apply for coverage? _____/___/_____

Does your health insurance provide coverage for prescription drugs? ☐ Yes ☐ No

Which of your prescribed HIV medication(s) is NOT covered by the plan? *Please list or attach*:

REFERRAL NEEDS

Have you seen your health practitioner in the past 6 months?	Yes ☐ No ☐
Have you had lab work done in the past 6 months?	Yes ☐ No ☐
Are you taking HIV medications?	Yes ☐ No ☐
Is your housing or living situation stable?	Yes ☐ No ☐
Is your ability to provide your daily living needs stable?	Yes ☐ No ☐
Do you have transportation resources to meet your needs?	Yes ☐ No ☐
Do you have issues with stress and/or depression in your life?	Yes ☐ No ☐
Do you have addictions or substance abuse issues in your life?	Yes ☐ No ☐
Do you want a referral for help with any of the above issues?	Yes ☐ No ☐
Do you have a crisis plan?	Yes ☐ No ☐
Do you have an HIV Case Manager?	Yes ☐ No ☐
Name & Agency:	

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SUPPORTING DOCUMENTATION GUIDE	
REQUIRED SUPPORTING DOCUMENTS – NEW APPLICANTS ONLY	
PROOF OF DIAGNOSIS	
	Lab report with your full name that shows measurable viral load by bDNA or PCR showing detectable virus level
	1) Positive HIV immunoassay AND positive confirmatory test, OR 2) Positive detectable HIV RNA reflecting the current algorithm approved by the Association of Public Health Laboratories (APHL).
	A statement signed by a prescribing medical professional on office letterhead or prescription pad indicating that the individual is HIV positive. An authenticated lab report, to confirm HIV status must be provided within 60 days.
REQUIRED SUPPORTING DOCUMENTS – ALL APPLICANTS	
PROOF OF MISSISSIPPI RESIDENCY	
	Income verification (check stubs with physical address, NO P.O. BOX)
	Utility bill in the individual's name
	Lease and/or rental agreement in the individual's name
	Valid Driver's License OR ID card issued by State Department of Motor Vehicles
	Statement from a homeless services provider on that provider's letterhead attesting to the individual's residence within the County area as a homeless individual
	A Letter of Award from Social Security, food stamps, TANF, VA, or SSI/SSDI
	A postcard/envelope addressed to the individual at his/her stated residence, with that correspondence having a postmark within 30 days from the date he/she is seeking eligibility certification. NOTE: A Post Office (P.O.) box alone is NOT an acceptable form by which to establish residency
	Ryan White case manager residency attestation
	For undocumented immigrants, a statement by the case manager and signed by the individual stating that the individual does not have a valid state ID due to his/her undocumented immigration status and does not possess any documents that could otherwise be used to verify residency.
PROOF OF INCOME (Must be below 300% Federal Poverty Level)	
IN ADDITION TO FORM 15- FINANCIAL STATUS FORM PLEASE PROVIDE…	
	Pay stubs for the pay periods (i.e., weekly, bi-weekly, monthly) showing a month's income before taxes and deductions within one (1) calendar month of application date.
	If unemployed, applicant may submit SSDI, TANF, Food Stamp, VA, private disability, unemployment, or retirement award letters
	Copy of most recent Federal Income Tax Return Transcript (1040, 1040A, 1040EZ) using Adjusted Gross Income line (unless self-employed)
	If self-employed, copy of 1040 Form for previous year with corresponding attachments (Schedule C or Schedule SE)
	MAGI Worksheet if no Tax Return submitted (Year One ONLY)
	Undocumented immigrants may submit a statement signed by the case manager or application assistor and the individual, stating that the individual does not hold a valid work permit from INS, and that the individual is not receiving any federal, state or country entitlements and that this has been verified by the agency.
	Applicants claiming to have zero income may submit a "No/Low Income Statement," for temporary DCP eligibility ONLY. Official income documents must be submitted within 30 days to maintain eligibility. ADAP applications can not be processed until official income information is received.
Please note that official Tax Return Transcripts will be requested annually during October recertification. http://www.irs.gov/Individuals/Get-Transcript	
Financial Status Forms must be completed with all members of the household and their income amounts. A household includes tax filers and their tax dependents, or for non-filers it includes the client, legal spouse, and any legal dependents.	
PROOF OF INSURANCE OR LACK OF COVERAGE	
IF INSURED…	
	Medicaid/CHIP card or approval letter
	Medicare card or approval letter
	Private insurance card [must provide copy of card (front and back), and Benefits Summary], can submit coverage notification letter until cards are received.
	Research of a third party query system to verify coverage. Must include plan details and effective dates.
IF NOT INSURED…	
	Medicaid/CHIP Denial- Denial due to failure to submit documentation is unacceptable.
	Certificate of Exemption from Healthcare.gov
	Application documents from Healthcare.gov (including application ID) listing premiums that are not affordable
	Termination of benefits (including COBRA) outside ACA open enrollment period

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Ryan White Part B Client Acknowledgement

Please initial each statement and sign below to complete your application.

_____ I may qualify for Ryan White funded services even if I have other insurance.

_____ I will report any changes to my household income, my address, and other things that may affect my services. If I do not, I may not be eligible or may have to re-pay the Ryan White Program.

_____ During April and October, I will complete the required eligibility recertification process. If I fail to provide documents, I will not remain in the program.

_____ The information provided in this application is true and accurate to the best of my knowledge. Any unreported items may result in loss of eligibility.

_____ I have received the Mississippi State Department of Health's HIPAA Statement and signed the corresponding HIPAA Acknowledgement statement.

_____ I have received and signed the Client Rights and Responsibilities statement.

_____ I have signed a release of information for the MSDH Treatment and Prevention Division and its contractors.

_____ I have completed Form 15- Financial Status Form and will submit it with this application.

Printed Name	Signature	Date

Signature of Legal Representative	Relationship to Client

MAGI WORKSHEET FOR APPLICANTS WITHOUT TAX RETURNS

Mock MAGI Worksheet

Only for use with applicant's who have not filed a tax return for the most recent tax year

Income types listed in ALL CAPS are not calculated in MAGI, but are required fields

For any income losses, enter negative $ amount

Client Name SS# – – DOB / /

Income Sources Total Monthly $ Amount for all Legal Household Members			
Wages, Salaries, tips, etc.		Pensions & Annuities (Veteran/Employer Based Pensions, Retirements,or Disability)	
Taxable Interest			
Tax Exempt Interest		Rental real estate,partnerships, S Corporations, Trusts, ect.	
Ordinary Dividends		Farm income or loss	
Taxable refunds of State/Local Income Taxes		Unemployment Income	
Alimony or other Spousal Support Received		Retirement Income from Social Security (SSA)	
Business Income/Loss		Disability Income from Social Security (SSDI)	
Capital Gain/Loss		SUPPLEMENTAL INCOME FROM SOCIAL SECURITY (SSI)	Specialty Line A
Other Gains/Losses		Other income (Jury Duty Pay, Gambling Winnings)	
IRA Distributions - Taxable amount		CHILD SUPPORT RECEIVED, WORKERS COMP, MONETARY GIFTS	Specialty Line B
Total Column 1		**Total Column 2**	
Total Income (Total Column #1 plus Total Column #2)			

Non MAGI (Not calculated but, required) Total Monthly $ Amount for all Legal Household Members			
Educator Expenses		Penalty on Early Withrawal of Savings	
Business Expenses		Alimony Paid	
Health Savings Account		IRA deduction	
Moving Expenses		Student Loan Interest Deduction	
Deductible Part of Self Employment Tax		Tuition and Fees	
Self Employed SEP, SIMPLE plans		Domestic Production Activities	
Self Employed Health Insurance Deduction			
Total Column 1		**Total Column 2**	
Total Adjustments (Total Column #1 plus Total Column #2)			
Add Specialty Line A			
Add Specialty Line B			
(Total Adjustments+ Spec Line A+Spec Line B) **= NON MAGI SUBTOTAL**			
		Total Income minus Non MAGI Subtotal above	
Modified Adjusted Gross Income (MAGI)			

Notes

Client Signature Date

(Signature, Date and Supporting Documentation is also required)

Revised 7/15/13

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ADAP/Ryan White Part B ONLY

MAGI INSTRUCTIONS

Eligibility Criteria for Medicaid and Insurance Affordability Programs: Modified Adjusted Gross Income (MAGI)[4]

	Income	Assets	Household size	Residency	Immigration status	Redetermination
MAGI	*Criteria* Based on Internal Revenue Service definition of income[1] MINUS: • Educator expenses • Business expenses • Health savings account deduction • Moving expenses • Certain self-employment expenses • Penalty on early withdrawal of savings • Alimony Medicaid-specific exceptions to MAGI definition of income: • Amount received as lump sum is only counted as income in month received • Educational grants are excepted from income • Certain American Indian/ Alaska Native income is excepted[2] • Across-the-board 5% disregard of income (all other income disregards eliminated) Budget periods: • MAGI income determinations are based on "point-in-time" income for Medicaid • Income determination for premium tax credits are based on projected annual income (credits are paid in advance and reconciled at end of year based on tax returns) • States have option of using point-in-time or projected annual income methods for *current* Medicaid beneficiaries and to take into account reasonably predictable income changes for new and current beneficiaries	*Criteria* No assets test	*Criteria* Tax filing unit (individual plus anyone for whom individual claims personal exemption) For individuals who do not file a tax return and are not claimed as tax dependent, household size is the individual and the following (if living with the individual): • Spouse • Natural, adopted, and step children (those under age 19, or, at state option those under age 21 and full-time student) • If applicant is a child, natural, adopted, and step parents and natural, adopted, and step siblings[3]	*Criteria* State of residence is the state where the individual is living and Intends to reside, including without a fixed address; or state in which person has entered with a job commitment or seeking employment (whether or not currently employed).	*Criteria* Undocumented immigrants are barred from coverage through exchanges or Medicaid Legal immigrants are barred from Medicaid coverage for 5 years, but are eligible for subsidized coverage through exchanges during this time.	*Criteria* Once every 12 months.
	Supporting documents The final regulation limits use of documentation and requires states to use electronic sources for verification wherever possible, including: • Internal Revenue Service (IRS) • State Wage Information Collection Agency • Social Security Administration (SSA); and • Other social services programs (e.g., SNAP) The regulation requires states to access information available through the federal "Data Services Hub" as well as the Public Assistance Reporting Information System (PARIS). If information obtained through electronic sources is not "reasonably compatible" with information provided by applicant, agency must request additional documentation.	*Supporting documents* N/A	*Supporting documents* Self-attestation accepted	*Supporting documents* Self-attestation accepted	*Supporting documents* Social Security Number or paper documentation (verification with federal data hub required)	*Supporting documents* States are required to use an administrative renewal process using electronic data sources. If eligibility cannot be verified with existing databases, beneficiaries must be sent a pre-populated renewal form and must supply missing information.

[1] IRS Form 1040 defines income as: wages, salaries, tips, interest, dividends, taxable refunds, credits or offsets of state and local income taxes, business income, capital gain, IRA distributions, pensions and annuities, rental real estate, royalties, partnerships, S corporations, trusts, unemployment compensation, and farm income.
[2] Exceptions include: distributions from Alaska Native corporations and settlement trusts, distributions from any property held in trust located within prior federal Indian reservation, distributions and payments from property rights associated with federal Indian reservation land, and student financial assistance under the BIA.
[3] Certain exceptions to MAGI household size rules apply, including the provision that married couples living together are each included in the other's household regardless of filing status. For a full list of exceptions (most of which involve treatment of children), see State Health Reform Assistance Network: Overview of Final Medicaid Eligibility Regulation (April 2012).
[4] MAGI applies to income determinations for newly-eligible Medicaid beneficiaries (the 2014 expansion population), some traditional Medicaid groups (children, parents, and caretakers), and subsidies to purchase insurance through exchanges. MAGI does NOT apply to certain traditional Medicaid groups (e.g., disabled populations and medically needy). Application of MAGI for new applicants will begin January 1, 2014. For current Medicaid beneficiaries, the MAGI formula will be effective on March 31, 2014 (or the next regularly scheduled renewal if later).

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