CURRENT HOUSING SITUATION (check one box)

☐ Stable/Permanent (example: House, Mobile Home, Apartment, or Institution)
☐ Unstable (example: Shelter, Vehicle, Homeless,)
☐ Temporary (example: Temporary w/ friends or family, Transitional housing)

PATIENT CAPS ON CHARGES

The Ryan White HIV/AIDS Program requires that individuals be charged no more than a maximum amount in a calendar year. The cap is based on the patient’s annual individual income and is set as a percent of patient’s annual income. UNC ID Clinic calculates the maximum amount of ID clinic charges according to the following criteria:

<table>
<thead>
<tr>
<th>Poverty Level*</th>
<th>Annual Income Level*</th>
<th>Maximum Charge Allowed</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;= 300%</td>
<td>&lt;= $35,010</td>
<td>$0</td>
</tr>
<tr>
<td>&gt; 300%</td>
<td>&gt; $35,010</td>
<td>No more than 10% of gross annual income.</td>
</tr>
</tbody>
</table>


If you want to qualify for a limit on the cost of your HIV care, receive Ryan White funded services in clinic or receive medications through HIV pharmacy programs, we need you to:

• Acknowledge that you are aware of the maximum allowable charges
• Acknowledge your responsibility to submit copies of your bills for HIV-related medical expenses to determine if you qualify
• Acknowledge your responsibility to submit documentation of your yearly income

By signing below, I acknowledge receipt of the Ryan White Patient Caps policy. It is my responsibility to provide receipted bills (either upon request or upon reaching the cap) for medical services to demonstrate payments to other providers.

Patient Signature ____________________________ Date __________

If you do not wish to receive Ryan White services:

DECLINATION OF RYAN WHITE SERVICES

By signing below, I decline services provided through Ryan White funding and wish to not provide income information that is required for Ryan White eligibility. I understand that if I wish to receive Ryan White services in the future, I can provide documentation to the UNC ID Clinic and my eligibility will be reviewed at that date.

Patient Signature ____________________________ Date __________

Last Updated 11/24/2014