Ryan White Part B/HMAP (HIV Medication Assistance Program) Eligibility Checklist

Client/Applicant Name: _____ **DOB:** _____

Checklist Completed By: _____ **Date Completed:** _____

This checklist must be completed by case managers at Ryan White Part B funded agencies during eligibility renewal periods. Ryan White Part B funded Agencies completing this form must keep this checklist and all documentation on file for Ryan White Part B monitoring. This checklist should not be sent to POMCS with HMAP applications.

Program(s):
- ❑ Ryan White Part B Only (Not HMAP)
- ❑ Ryan White Part B and HMAP

1. Proof of Income is required for the applicant and all countable family members (individuals related to the applicant by blood, marriage or adoption, live in the same household and share a financial responsibility).

Preferred documentation:
- ❑ Most recent paycheck stub (showing year to date income and deductions) and copy of Income Tax Return for the previous year

Other acceptable forms of documentation include:
- ❑ Most recent paycheck stub (showing year to date income and deductions) and last paycheck stub (showing year to date income and deductions) for previous year
- ❑ Most recent paycheck stub (showing year to date income and deductions) and Form W-2 for previous year
- ❑ Most recent paycheck stub (showing year to date income and deductions) and Form 1099 for previous year (or most recent earning period if 1099 is not yearly)
- ❑ Most recent Social Security income letter
- ❑ Documentation of other sources of income (e.g. Unemployment)

Individual reports no income:
- ❑ Ryan White Part B/HMAP "Verification of No/Low Income" sheet

Individual reports low income (defined as at or below 125% of the Federal Poverty Guidelines):
- ❑ Ryan White Part B/HMAP "Verification of No/Low Income" sheet (For HMAP Applicants only)

Individual reports income but proof of income is not available:
- ❑ Ryan White Part B/HMAP Income Signature Card

2. Proof of North Carolina Residency is required for all applicants whose current name and address are not included on their proof of income.

Preferred documentation:
- ❑ Copy of valid NC Driver's License or government-issued identification card with name and home address

Other acceptable forms of documentation:
- ❑ Copy of a utility bill or lease with applicant's name and current address

Last resort for documentation:
- ❑ Anything with applicant name and home address or the Ryan White Part B & HMAP Declaration of Residency (clients will be expected to provide a preferred or other acceptable documentation of residency by the next renewal period)

3. Proof of Insurance or Medicare/Medicaid:
- ❑ Copy of insurance card(s)
- ❑ If there is an insurance cap, letter/summary from insurance company or specific proof from the insurance policy
- ❑ Copy of Medicare card (If income is at or below 150% of the Federal Poverty Guidelines, client must apply for Social Security's low-income subsidy (LIS) also known as "extra help"
- ❑ Copy of Medicare Part D plan card (this is different from the Medicare card)
- ❑ Copy of Medicaid card
- ❑ Efforts to "Vigorously Pursue" other sources of health coverage have been documented

1. POMCS/HMAP Case Number

2. Last Name First Name MI

3. Social Security Number

4. Date of Birth (MM/DD/YYYY)

N.C. Department of Health and Human Services
Division of Public Health
Purchase of Medical Care Services
1907 Mail Service Center
Raleigh, NC 27699-1907

DHHS 3014/3056

Financial Eligibility/ Authorization Request

5. Current Gender ☐1. Male ☐2. Female ☐3. Transgender (Male to Female) ☐4. Transgender (Female to Male) ☐5. Transgender (Unknown)

Program RW | Diagnosis Code

6A. Race ☐1. White ☐2. Black/African American ☐3. American Indian or Alaska Native ☐4. Asian ☐5. Native Hawaiian/Pacific Islander ☐6. Unknown ☐7. More Than One Race

10. HMAP Sub-program
☐1. UMAP (No Insurance) ☐2. SPAP (Medicare Part D)
☐3. ICAP (Qualified Health Plan on the Federal Marketplace–COPAY Only)
☐4. PCAP (Qualified Health Plan Premium/Copay Assistance)

6B. Race Subcategory
Asian: ☐1. Asian Indian ☐2. Chinese ☐3. Filipino ☐4. Japanese ☐5. Korean ☐6. Vietnamese ☐7. Other Asian
NH/PI: ☐1. Native Hawaiian ☐2. Guamanian or Chamorro ☐3. Samoan ☐4. Other Pacific Islander

11. Application Type/Requested Dates of Service
☐1. New Application (Immediate Coverage)
☐2. Summer Renewal (October 1 to March 31)
☐3. Winter Renewal (April 1 to September 30)
☐4. New Application (Delay Start Date)
Requested Start Date:
Explanation (Documentation Required)

7A. Ethnicity ☐1. Hispanic/Latino(a) ☐2. Non-Hispanic

12. N.C. Resident? ☐1. Yes ☐2. No

7B. Ethnicity Subcategory
Hispanic: ☐1. Mexican, Mexican American, Chicano/a ☐2. Puerto Rican ☐3. Cuban ☐4. Other Hispanic, Latino/a or Spanish Origin

13. Incarcerated? ☐1. Yes ☐2. No
Local County Jail (Name)

8. Language ☐1. English ☐2. Spanish ☐3. Other (Specify)

14. Applicant's Street Address (Must match documentation of residence)

9. **Countable Family Members** (Including Applicant)
Number of Adults _____
Number of Children _____
Total Number _____

15. City State Zip Code

16. Telephone Number (Include Area Code)
(Home/Cell) (Work)

17. County of Residence Applicant's County Code (see Page 3)

18. Applicant's Mailing Address
☐Check if the address is the same as above
Care of, if applicable
Address (Street or RFD)
City/State/Zip Code

INCOME FORMULAS: Regular **(R)**—Continuously employed wage earners list income for the 12 months before the date of application or the requested date of coverage, whichever is earlier. Unemployment **(U)**—Wage earners unemployed at the time of application or for 30 consecutive days during the previous 12 months list income for 6 months before and after the date of application or the requested date of coverage whichever is earlier. **Must report Gross and Net Income.**

19. Complete for All Countable Family Members Name	Relationship to Patient	Income Formula (R or U)	List all Employers or Sources of Income/Reason for None for 12 Month Period	Dates From	Dates To	Gross Income	Income After Taxes

20. Explain Means of Support: (Check each item that is applicable)
☐Community Support ☐Medical Assistance
☐Family Support ☐Migrant Worker
☐Food Stamps/EBT ☐Transportation Assistance
☐Housing Assistance ☐Utility Assistance
☐Other, specify: _____
☐Unemployment Benefits, specify dates: _____

22. Has the applicant applied for: (Check either Yes or No to each item)
Medicaid: ☐Yes ☐No
Medicare: ☐Yes ☐No ☐NA, Automatically Enrolled
Medicare Part D: ☐Yes ☐No (If yes, complete box 24)
SS LIS Application: ☐Yes ☐No ☐NA
If yes for LIS, provide date: (MM/DD/YYYY)

21.	Gross Income	Income After Taxes
Annual Gross Income (include Annual Gross Income and Annual Net Income)		
Federal, State & Social Security Tax		
Total Income After Taxes (Difference Between Both Lines)		
Medical expenses paid or incurred during past 12 months not covered by a third party nor requested for program coverage		
Other deductions: (Specify, deduction(s))		
Total Deductions		
Annual Net Income		

CASE NUMBER	Last Name	First Name	MI

23. PRESCRIPTION DRUG INSURANCE COVERAGE: Provide complete insurance information and copies of insurance cards for all countable family members.
Not Applicable ☐
Insurance Company/Plan Name:
RXBIN:
RXPCN:
RXGRP:
Policyholder:
Is patient covered? ☐Yes ☐No
Does insurance have a cap? ☐Yes ☐No
If yes, provide amount and submit documentation: $

24. MEDICARE PART D COVERAGE: Provide complete information.
Not Applicable ☐
Insurance Company/Plan Name:
RXBIN:
RXPCN:
RXGRP:
Policyholder:

25. Has the applicant used tobacco products four or more times per week in the past six months? ☐1. Yes ☐2. No

26. Do you have a current diagnosis for Hepatitis C? ☐1. Yes ☐2. No

27. Housing Arrangement?
☐1. Stable/Permanent ☐2. Temporary ☐3. Unstable

28. First HIV/AIDS Diagnosis Date (Include Month and Year, If Known)
☐1. Month (MM)
☐2. Year (YYYY)
☐3. Unknown

29. HIV/AIDS Status
☐1. HIV Positive–Not AIDS
☐2. HIV Positive–CDC defined AIDS
☐3. HIV Positive–AIDS Status Unknown

30. Interviewer's Information (Requesting Office)
Interviewer's Name:
Agency:
Address:
County Code (see Page 3):
Phone Number:

31. Alternate Clinical/Professional Contact
Last Name First Name MI
Phone Number:

32. Clinician's Information
Clinician's Name:
N.C. License #:
Agency:
Address:
County Code (see Page 3):
Phone Number:

I hereby certify that I have read or the interviewer has read to me the terms and conditions described within and that I agree to comply with them. I also certify that I have been provided an opportunity to ask the interviewer questions about these terms and conditions and that I understand the answers I was given.

33. **Applicant's Signature** **Relationship to Applicant** **Current Date** (MM/DD/YYYY)

I certify that I have explained the terms and conditions contained within and have witnessed his/her signature.

34. **Interviewer's Signature** **Current Date** (MM/DD/YYYY)

I certify that the above named individual is HIV Positive and has prescriptions for a medication listed on the current N.C. ADAP Formulary.

35. **Clinician's Signature** **Current Date** (MM/DD/YYYY)