

Date of Review: ____/____/____

Date of next review:	____/____/____
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1. Client Information

First Name: _____ Last Name: _____

Date of Birth: ____/____/____

Sex at Birth: Male Female Gender Identity: Male Female Transgender (MTF) Transgender (FTM)

2. Residency Status

Does the client live in the Columbus TGA? Yes No Zip Code: _____

Documentation:

- Copy of state issued identification card or driver's license
- Copy of mail from a utility or service providing company that confirms client's residency
- Copy of mail from a government agency that confirms client's residency
- Copy of a lease or mortgage statement that lists the client
- A professional's verification letter following a visit to the client's home
- A signed letter from a homeless service provider verifying homelessness
- A signed letter, including contact information, from person providing housing indicating client resides at address
- Signed attestation by the client confirming residency (*may be utilized only one time in a twelve-month period*)
- Signed homeless declaration form by client confirming residency (*may be utilized only one time in a twelve-month period*)
- Exception Form submitted to and approved by Columbus Public Health

3. Income Status

Does the client meet the "low-income" requirement? Yes No

Low-income is defined as less than 500% FPL using the MAGI methodology.

Annual Income: \$ _____ Household Size: _____ Federal Poverty Level: _____

Documentation:

- Copy of most current IRS Tax Transcript (three (3) years of tax transcripts if self-employed)
- Completed MAGI Worksheet with a copy of four (4) consecutive weeks of pay stubs
- Completed MAGI Worksheet with letter from employer stating earnings
- Completed MAGI Worksheet with copies of court orders for alimony or other court-ordered payments, excluding child support
- Completed MAGI Worksheet with copies of award letters for benefits from federal, state or county entitlement programs
- Signed attestation by the client stating their income, including if the client has no income (*may be utilized only one time in a twelve-month period*)
- Exception Form submitted to and approved by Columbus Public Health

4. Insurance Status

Does the client have health insurance? Yes No

If "YES", indicate primary insurance type:

- Private—Employer
- Private—Individual
- Medicare
- Medicaid, CHIP or other public plan
- Veterans Health Administration (VA), military health care (TRICARE), or other military health care
- Indian Health Service
- Other (*not listed above*)

Documentation:

- Copy of current insurance card
- Proof that the service is not covered by other third party insurance programs (*Military Veterans with VA benefits are eligible for Ryan White services*)
- Signed attestation from a professional stating the client is not eligible for health insurance coverage
- Copy of pending application, if potentially eligible
- Signed attestation that the client was informed of health insurance coverage options and the benefits of applying for health insurance coverage, but opted not to apply (*Ryan White services shall not be denied based upon client's informed decision to abstain from health insurance*)
- Exception Form submitted to and approved by Columbus Public Health

5. Ryan White Part A Approval

By signing this form, I verify that all client eligibility information has been properly reviewed and documented per Columbus Public Health policy and that the client is approved to access Columbus Ryan White Part A services.

Printed Name

Organization

Signature

____/____/____
Date