THE CITY OF COLUMBUS
ANDREW J. GINTHER, MAYOR
COLUMBUS PUBLIC HEALTH

# Ryan White Part A Eligibility Form
# INITIAL ASSESSMENT

**Date of Initial Assessment:** _____/_____/_____

## 1. Client Information

**First Name:** _____ **Middle Name:** _____

**Last Name:** _____ **Date of Birth:** _____/_____/_____

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

## 2. Client Demographics

**Race:** *(Check all that apply)*
☐ White ☐ Black or African American ☐ American Indian or Alaskan Native ☐ Asian

**If Asian, please specify:** ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other

☐ Native Hawaiian or Pacific Islander

**If Native Hawaiian or Pacific Islander, please specify:** ☐ Native Hawaiian ☐ Samoan ☐ Guamanian or Chamorro ☐ Other

**Ethnicity:**
☐ Not Hispanic/Latino(a)
☐ Hispanic/Latino(a)

**If Hispanic/Latino(a), please specify:** ☐ Mexican, Mexican American, Chicano(a) ☐ Puerto Rican ☐ Another Hispanic, Latino(a) or Spanish Origin ☐ Cuban

## 3. HIV Status

**HIV Status:** ☐ HIV-positive, not AIDS ☐ HIV-positive, AIDS status unknown ☐ CDC-defined AIDS

**HIV-positive Date:** _____/_____/_____

**Documentation:**
☐ Copy of a CTR or other CLIA certified laboratory report of an HIV-positive test result
☐ Documentation confirming HIV-positive status in Ohio Disease Reporting System (ODRS)
☐ Official paperwork from a physician or advanced nurse practitioner confirming client's HIV-positive status
☐ Copy of Ohio Department of Health HIV Verification Form, completed by a DIS or CRT certified professional, verifying HIV-positive status
☐ Proof of prescription for HIV medication
☐ Exception Form submitted to and approved by Columbus Public Health

## 4. 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
☐ Copy of a current pay stub that lists the client's residency
☐ 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

## 5. 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

## 6. 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

## 7. 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*

| **Date of next review:** | _____/_____/_____ |
|---|---|