Ryan White Part A

Patient Approval Form

Date: _____/_____/_____

Dear Healthcare Provider:

The following patient is approved and validated to receive medical services under your Ryan White Part A contract until the expiration date listed below:

Client's First Name: _____ Client's Last Name: _____

Date of Birth: _____/_____/_____

Ryan White # *(if applicable)*: _____ ETO # *(if applicable)*: _____

Approval Date: _____/_____/_____ Expiration Date: _____/_____/_____

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.

_____ _____
Professional's Printed Name *Title*

_____ _____
Organization *Phone Number*

_____ _____/_____/_____
Professional's Signature *Date*