STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH & HUMAN SERVICES
NH RYAN WHITE CARE PROGRAM

603-271-4502 800-852-3345 x4502
TD Access: 800-735-2964

NH CARE APPLICATION

☐ Initial Application

☐ Renewal

Application Date: _____

Last Name	First	DOB	Social Security #
Physical Address			Birth Country

Can we mail you information? ☐ Yes ☐ No

If no, alternate mailing address:

Home phone ( ) Cell phone ( ) Can we leave you a detailed voicemail? ☐ Yes ☐ No

Do you work with a case manager at an AIDS Service Organization? ☐ Yes ☐ No

Name: Organization:

HIV Care Physician:	Pharmacy:
City/State: Phone:	City: Phone:

Gender Identity: ☐ Male ☐ Female ☐ Transgender M to F ☐ Transgender F to M ☐ Declined

Sex at birth: ☐ Male ☐ Female

Ethnicity: ☐ Non-Hispanic ☐ Hispanic (specify)

- ☐ Mexican
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Other Hispanic _____

Race:

- ☐ White
- ☐ Black/African American
- ☐ American Indian/Alaska Native

☐ Asian (specify):

- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian _____

☐ Native Hawaiian/Pacific Islander (specify):

- ☐ Native Hawaiian
- ☐ Guamanian
- ☐ Samoan
- ☐ Other _____

What is your preferred language: ☐ English ☐ Spanish ☐ French ☐ Other: _____

What is the first three (3) letters of your mother's first name: (needed to create your ID code)

HOUSING STATUS
☐ Stable/Permanent ☐ Temporary ☐ Unstable

INCOME INFORMATION
Number of persons in your household?

Source(s) of income	Weekly	Monthly	Yearly
Wages			
Other (explain):			
Other (explain):			
Totals:			

Proof of income (most recent)	
☐ Pay Stub	☐ Social security or unemployment check
☐ Federal Income Tax	☐ Bank Statement
☐ Employer letter stating wages	☐ Other:
Note: If your income exceeds 400% of the federal poverty level, proof of medical expenses can be submitted to spend down" and qualify you for the program, ask for details.	

MEDICAID (applicants are **required** to apply to Medicaid once per year)	
Have you applied for Medicaid? ☐ Yes ☐ No	Date applied:
Approved: ☐ Yes ☐ No ☐ Pending	ID#

MEDICARE PART A and B	
Part A: ☐ Yes ☐ No ☐ Unknown	Start Date:
Part B: ☐ Yes ☐ No ☐ Unknown	Start Date:

MEDICARE PART D	
Part D: ☐ Yes ☐ No ☐ Unknown	Start Date:
Plan name:	ID#

INSURANCE (you may qualify for assistance with insurance premiums)	
Are you covered by medical health plan: ☐ Yes ☐ No	Is this a Military or VA plan: ☐ Yes ☐ No
Plan name:	ID#

By signing below, I certify that I have read, understand, and comply with the Non-Discrimination Notice, Client Certification, Grievance Procedure and Review of Records.

Non-Discrimination Notice

The State of New Hampshire, Department of Health and Human Services, does not discriminate against people because of their age, sex, race, creed, color, marital status, familial status, physical or mental disability, national origin, sexual orientation or political affiliation or belief. There will be no discrimination in accepting or providing services, or the admission or access to, or treatment or employment in, any of the Department's programs or activities. The Controller is responsible for coordinating the civil rights compliance efforts of the Department, component offices and divisions to follow state and federal rules against discrimination. For more information or to learn how to make a discrimination complaint, contact the Controller at 129 Pleasant Street, Concord, New Hampshire 03301; or you may telephone 603-271-4963 (voice) or the TDD Access number: 800-735-2964. The New Hampshire Department of Health and Human Services is subject to Title VI of the Civil Rights Act of 1964 (42 U.S.C., Section 2000d et. seq.); Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C., Section 794); Title IX of the Education Amendments of 1972 (20 U.S.C., Section 1681); the Age Discrimination Act of 1975 (42 U.S.C., Section 6101 et. seq.); NH RSA 354-A; and certain federal block grant statutes, including, but not limited to 42 U.S.C., Sections 300x-7, and 708, or any other provision through which the Department receives federal financial participation in its programs. These laws prohibit discrimination on the basis of age, sex, race, creed, color, marital status, familial status, physical or mental disability, national origin, sexual orientation or political affiliation or belief in federally-assisted and state funded activities. The U.S. Department of Health and Human Services' regulations under Title VI, Section 504, Title IX and the Age Discrimination Act are found at 45 C.F.R., Parts 80, 84, 86 and 91, respectively. The New Hampshire Department of Health and Human Services is further subject to the Americans with Disabilities Act of 1990 (42 U.S.C., Section 12101, et. seq.) and its implementing regulations at 28 C.F.R., Part 35.

Client Certification

1. I hereby declare that my financial statements are correct and true to the best of my knowledge. I understand that any intentional misrepresentation may result in legal action against me on the basis of state or federal laws. Furthermore, I understand that I will be denied participation if I withhold information, provide inaccurate information, or refuse to provide all of the necessary information. I agree to notify the NH CARE Program within 30-days of any change in my name, address, eligibility, financial, insurance status or household size, and to provide evidence of income and medical expenses, Medicaid or Medicare status, and/or health insurance policy. I fully agree to comply with the conditions stated herein and agree to repay the NH CARE Program immediately for any funds inadvertently or erroneously paid to me or on my behalf.
2. In order to be considered for participation in the NH CARE Program, I hereby authorize my physician or his/her representative to release information requested by the NH CARE Program relative to the content of my medical record. I understand that this information will be maintained under strict conditions of confidentiality. All information given to the NH CARE Program is confidential and will not be released to any other parties unless allowed under the law or as authorized below.
3. I hereby authorize the staff of the NH CARE Program to communicate with and release information, including my diagnosis, to appropriate physicians and other health care professionals including my pharmacist, case manager and other treatment providers, as well as third-party insurance administrators to ensure the best possible planning and delivery of services on my behalf. If I am applying for insurance continuation, I authorize the NH CARE Program to speak with my employer and/or insurance or COBRA provider regarding my status and may contact any third party payers/administrators to ensure coverage and resolve billing issues. This release is valid for one (1) year from signature unless revoked by me in writing.

Grievance Procedure

1. If you are dissatisfied with a denial of enrollment, within 30 days of the date of the NH CARE Program's notification letter, you may request an informal case review conference by contacting the NH CARE Program Manager at 800-852-3345 x3958.
2. The NH CARE Program shall notify you within 14 days after the informal case review conference whether the NH CARE Program will reverse the denial of enrollment. If you are still dissatisfied with the response, you will have the opportunity to request a hearing with the Department's Administrative Appeals Unit, which shall be held in accordance with NH RSA 541-A.
3. You may contact the NH DHHS Office of Ombudsman at any point in the process for a neutral resolution of your complaint at 800-852-3345 ext. 6941.

Review of Records

I understand that the NH Department of Health and Human Services and/or City of Boston/Trustees of Health and Hospitals, which provides funding for this program, may access my record during provider site visits, for the purpose of review for oversight purposes only, to include: my name, HIV status, related diagnoses, substance abuse treatment, medical care/treatment, financial circumstances, living arrangements, and other information as requested. Only the minimum amount of information necessary to perform oversight shall be accessed. I understand the review is visual only and no records shall be copied, recorded, or removed.

Applicant/Guardian Signature Date

Witness Signature Date

Physician's Release of Information

I hereby authorize my physician or physician's representative, to release information requested by the NH CARE Program, relative to the content of my medical record. I understand that this information will be maintained under strict confidentiality, will not be revealed to persons outside the NH Department of Health and Human Services, and will be used solely for my benefit. This release is valid for one (1) year from date of signature unless revoked by me in writing.

Applicant/Guardian Signature Date

Printed Name

Witness Signature Date

Physician's Information

Physician Name

Hospital/Clinic Name City/Town

Phone # Fax # (optional)

APPLICANT CHECKLIST

(please keep for your records)

- ☐ Applications are good for six months. At the end of six months you will need to submit a new application. If your enrollment expires, you will not be eligible for services.
- ☐ Applicants are required to apply to Medicaid one time per year. Your application can be denied if this requirement is not met.
- ☐ The "Patient Medical Information" (pg. 6), must be completed by a physician. It can be faxed to the NH CARE Program at 603-271-4934.
- ☐ Attach a copy of your insurance or medicare card.
- ☐ Attach a copy of your last two pay stubs OR social security check OR unemployment check OR federal income tax return.
- ☐ If you have no income, your case manager will need to write a letter stating you have no income.
- ☐ Mail my application to the CARE Program at: **DHHS- NH CARE Program, 29 Hazen Drive, Concord NH 03301.**

NH CARE Program
8:30 – 4:30
Monday thru Friday

Main Office: (603) 271-4502 (800) 852-3345 x4502
CARE Manager: (603) 271-3958 (800) 852-3345 x3958

NH CARE Program Patient Medical Information (PMI)

This information is required to determine the client's eligibility for the NH CARE Program and must be completed by a physician. Please fax to the patient's Case Manager. Forms may also be faxed to the NH CARE Program at 603-271-4934.

Sdx #	Last Name	First Name	MI	DOB

Date of Most Recent Office Visit:

	HIV-positive (not AIDS)	Diagnosis date:	☐ Est
	HIV-positive (AIDS status unk)	Diagnosis date:	☐ Est
	CDC defined AIDS	Diagnosis date:	☐ Est

Lab Values	
CD4 Count:	Viral Load:
Date of Most Recent:	Date of Most Recent:

Mode of transmission (select all that apply)			
	Male who has sex with male(s)		Perinatal Transmission
	Injecting Drug Use		Receipt of transfusion of blood, blood components, or tissue
	Hemophilia/Coagulation Disorder		Not reported or identified
	Heterosexual Contact		

Prescribed Antiretroviral medication(s).

Physician Signature Date

Hospital/Clinic Address Phone