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

☐ Initial Application
☐ Renewal
☐ Reinstatement

NH RYAN WHITE CARE APPLICATION

Application Date:

Last Name	First	Middle Initial	DOB	Social Security #

Physical Address	Birth Country

Mailing Address (if different than above): Can we mail you information? ☐ Yes ☐ No

If no, please list an alternate mailing address:

Email Address Can we email you information? ☐ Yes ☐ No

Home phone	Cell phone	Alt phone	Can we leave you a detailed message? ☐ Yes ☐ No
(603) 271-0560	( )	( )	

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

Gender Identity: ☐ Male ☐ Female ☐ Transgender M to F ☐ Transgender F to M ☐ Non-Binary ☐ Declined to share ☐ Other

Sex assigned at birth: ☐ Male ☐ Female ☐ Other ☐ Declined to share

Race (check all that apply):
☐ American Indian/Alaska Native
☐ Black/African American
☐ White
☐ Other

☐ Asian (please specify):
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian:

☐ Native Hawaiian/Pacific Islander (please specify):
☐ Native Hawaiian
☐ Guamanian
☐ Samoan
☐ Other:

Ethnicity: Hispanic or Latino/a/x
☐ Yes ☐ No

☐ Mexican, Mexican American, Chicano/a
☐ Puerto Rican
☐ Cuban
☐ Other Hispanic: Latino/a/x or Spanish origin (please specify):

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

Do you require interpretation services for speaking? ☐ Yes ☐ No For document translation? ☐ Yes ☐ No

Do you work with a Case Manager at an AIDS Service Organization (ASO)? ☐ Yes ☐ No

Case Manager Name: Agency:

RESIDENCY (proof of NH Residency is required) please attach one of the following documents:

Current rental/lease agreement, mortgage, property tax, or bank statement, pay stub/check, government issued document i.e. social security statement, utility bill, NH car registration, NH driver's license or other form of official photo identification. If you do not have a residence, your Case Manager can provide a letter attesting to your housing status and should be signed and dated by both parties.

My current housing status is: ☐ Stable/Permanent ☐ Temporary ☐ Unstable

HOUSEHOLD SIZE (number of persons in your household):

Household is defined as: client, client's parent(s), client's spouse, client's children under 21 and is living with the client (even if they file a tax return themselves), anyone the client includes on their tax return as a dependent (even if they do not live with the client), anyone under 21 who is taken care of by the client and who is living with the client, client's unmarried partner (if one or both of these apply: they are your dependent for tax purposes, they are the parent of your child).

HOUSEHOLD INCOME: If you do not have an income, your Case Manager can provide a letter attesting to your income status and it should be signed and dated by both parties. Explanation as to how you support yourself must be provided.

	Weekly	Monthly	Yearly
Wages			
Other (explain):			
Other (explain):			

Please provide copies of all applicable income documents

☐ Pay Stubs (2 consecutive & most recent)	☐ Employer letter stating wages (signed & dated)
☐ Social security statement or unemployment check	☐ No income attestation letter from Case Manager
☐ Federal Income Tax (prior approval by NH CARE required)	☐ Bank Statement (prior approval by NH CARE required)

MEDICAID (attach copy of your card) Applicants are required to apply to Medicaid one time per year if Household Federal Poverty Level is < 200%.

Have you applied to Medicaid? ☐ Yes ☐ No Date applied:	Plan Name:
Approved: ☐ Yes ☐ No ☐ Pending	ID# Effective Date:

MEDICARE PART A and B (attach copy of your ID card)

Part A: ☐ Yes ☐ No ☐ Unknown	Effective Date:
Part B: ☐ Yes ☐ No ☐ Unknown	Effective Date:

MEDICARE PART D (attach copy of your ID card)

Part D: ☐ Yes ☐ No ☐ Unknown	Effective Date:
Plan name:	ID#

MEDICAL HEALTH INSURANCE (attach copy of your ID card) You may qualify for assistance with insurance premiums, please ask.

Are you covered by medical health plan? ☐ Yes ☐ No ☐ Unknown	Effective Date:
Plan name:	ID#
Type of plan: ☐ Family/Spouse ☐ Employer Sponsored ☐ Military/VA ☐ ACA/Marketplace ☐ Unknown	

DENTAL INSURANCE (attach copy of your ID card)

Do you currently have dental insurance? ☐ Yes ☐ No ☐ Unknown	Effective Date:
Plan name:	ID#

MEDICAL PROVIDER INFORMATION

HIV Medical Provider Name	Address	Phone
Pharmacy Name	Address	Phone

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 NH DHHS Office of Ombudsman 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 or subsequently repaid by any other party through any claims or actions.
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 for the purpose of certification of eligibility, coordination of care, and support service delivery and payments. 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 premium payment program, I authorize the NH CARE Program to contact third party payers/administrators, including my employer if applicable, to confirm insurance plan and enrollment dates to verify coverage periods 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 Boston Public Health Commission, which provide 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

HIV Medical Provider Name

Hospital/Clinic Name City/Town

271-0560

Phone Fax (optional)

NH Ryan White CARE Program Patient Medical Information (PMI)

The PMI is required to determine a person's eligibility for the NH CARE Program. It must be completed in full by a medical provider staff member, signed by a licensed medical provider, and faxed to the client's AIDS Service Organization (ASO) Case Manager. The PMI is due every six (6) months at time of the NH CARE Program enrollment.

Sdx #	Last Name	First Name	MI	DOB

Date of Most Recent Office Visit:

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

Lab Values	
CD4 Count: Date of Most Recent:	Viral Load: 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 Therapy (ART) medication(s):

Infectious Disease Licensed Professional Signature Date

Hospital/Clinic Name Address