Ryan White Financial Assistance Request Form

CLIENT INFORMATION

Client eURN: _____
(Case Sensitive eURN)

Client DOB: _____

- ☐ Client is Homeless
- ☐ Client is Chronically Homeless
- ☐ Client is Pregnant
- ☐ Client is Female Head of Household

(must have custody of dependent child)

County of Residence

- ☐ Adams
- ☐ Arapahoe
- ☐ Broomfield
- ☐ Denver
- ☐ Douglas
- ☐ Jefferson

Zip Cod _____
(Zip code is required for each FAR submitted)

Gender

- ☐ Male
- ☐ Female
- ☐ Transgender

HIV Diagnosis

- ☐ HIV+ Asymptomatic
- ☐ HIV+ Symptomatic
- ☐ AIDS, yr of diagnosis _____ (if known)
- ☐ HIV+, but AIDS status unknown

Client Ethnicity
(check all that apply)

- ☐ African American or Black
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Latino/Latina
- ☐ Pacific Islander or Native Hawaiian
- ☐ White or Caucasian
- ☐ Other: _____
- ☐ Mixed: _____

Client Transmission
(check all that apply)

- ☐ Opposite sex contact
- ☐ Same sex contact
- ☐ Transfusion
- ☐ Sharing needles/IDU
- ☐ Born HIV infected
- ☐ Don't know

Primary HIV Medical Care

- ☐ Denver Health
- ☐ University Hospital
- ☐ Children's ID Clinic
- ☐ Clinica Tepeyac
- ☐ VA ID Clinic
- ☐ Kaiser
- ☐ Private Infectious Disease Doctor
- ☐ MCPN
- ☐ None
- ☐ Other _____ (please specify)

Insurance/Medical Assistance Programs

- ☐ Medicaid
- ☐ Medicare A
- ☐ Medicare B
- ☐ Medicare D
- ☐ Private or Employer Plan
- ☐ CICP
- ☐ DFAP
- ☐ ADAP
- ☐ VA
- ☐ None
- ☐ Other _____ (please specify)

HOUSEHOLD INFORMATION

Household Members: List all people living in the household (including dependents)

Name	Gender	Ethnicity	Date of Birth	Spouse, Partner, Dependent or Roommate	HIV Status	If Dependent, Custody?	Monthly Gross Income (Exclude Roommate)	Source of Income	Verification Date
Client				**Client**					
	M / F / T		/ /	S / P / D / R		Y N N/A			
	M / F / T		/ /	S / P / D / R		Y N N/A			
	M / F / T		/ /	S / P / D / R		Y N N/A			
	M / F / T		/ /	S / P / D / R		Y N N/A			
	M / F / T		/ /	S / P / D / R		Y N N/A			
	M / F / T		/ /	S / P / D / R		Y N N/A			
	M / F / T		/ /	S / P / D / R		Y N N/A			

Household Size: _____ # of Dependents: _____ Total Household Income: _____

Living Situation Prior to Assistance

- ☐ Don't Know or Refused
- ☐ Emergency Shelter/Motel (Paid for w/Voucher)
- ☐ Foster care home or foster care group home
- ☐ Hospital
- ☐ Hotel/Motel paid for by Client
- ☐ House owned by Client
- ☐ Jail, prison or juvenile detention facility
- ☐ Transitional Housing for homeless persons
- ☐ Permanent Housing for formerly homeless
- ☐ Place not meant for human habitation
- ☐ Psychiatric hospital/facility
- ☐ Rented room, apartment or house
- ☐ Staying or living in someone else's place
- ☐ Substance abuse treatment facility or detox

Sources of Household Income

- ☐ AND
- ☐ SSDI
- ☐ SSI
- ☐ TANF
- ☐ Employment
- ☐ Untaxed/Unreported
- ☐ Emp. Disability
- ☐ Pension
- ☐ VA
- ☐ No Income
- ☐ Aid to the Blind
- ☐ Child Support
- ☐ Food Stamps $ _____
- ☐ Other: _____

☐ Other: _____

ASSISTANCE INFORMATION

Emergency Assistance

Assistance Amount Requested: $ _____

Due Date or Date of Service: _____

- ☐ Insurance Premium
- ☐ Medical Co-pays (Rx or Dr Visits w/ current statement)
- ☐ Phone (Basic current service, $35 maximum)
- ☐ Utilities (current bill only)
- ☐ Water/Sewer (current bill only)

Pay To Information:

Pay to: _____

Address: _____

City, State & Zip: _____

Distinguishing Info: _____

Emergency Housing Assistance

Assistance Amount Requested: $ _____

First Day of Month to be Covered _____

Total Rent: $ _____
(Full rent listed on lease)

Client Portion of Rent: $ _____
(Rent amount client is responsible for)

Pay To Information:

Payee confirmed w/Assessor's office: ____Yes ____ No

Pay to: _____

Address: _____

City, State & Zip: _____

Distinguishing Info: _____

Date Agency was provided Proof of County Residence: _____

Supportive Documentation of Residence: _____

I hereby attest that all of the above information is true and correct as verified by me based on documentation received (either directly from the client or a reliable third party) and is on file in our office in a client specific file maintained here.

Referring Agency: _____ Telephone Number: _____

Referring Case Manager: _____ Fax Number: _____

Authorized Signature: _____ Date: _____

It is the responsibility of each Case Management organization to assure that this client is eligible for assistance based on the current Ryan White Housing and Emergency Assistance Standards of Care.

All sections must be completed. Any incomplete information will cause a delay in processing until the information is completed.

Fax completed forms to 303-468-0487

Form Revised 06/2013 by TSmith