

Ryan White Financial Assistance Request Form

CLIENT INFORMATION

Client eURN: _____
(Case Sensitive eURN)

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

Client DOB: _____

County of Residence

- Adams
- Arapahoe
- Broomfield
- Denver
- Douglas
- Jefferson
- Other

Gender

- Male
- Female
- Transgender

HIV Diagnosis

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

Zip Code: _____
(Zip code is required for each FAR submitted)

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
- Undisclosed

Client Transmission

(check all that apply)

- Opposite sex contact
- Same sex contact
- Transfusion
- Sharing needles/IDU
- Born HIV infected
- Don't know
- Undisclosed
- None

Primary HIV Medical Care

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

Insurance

- | | | |
|--|---|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare A <input type="checkbox"/> Medicare B <input type="checkbox"/> Medicare D | <ul style="list-style-type: none"> <input type="checkbox"/> Private or Employer Plan <input type="checkbox"/> CACP <input type="checkbox"/> CHS <input type="checkbox"/> ADAP | <ul style="list-style-type: none"> <input type="checkbox"/> VA <input type="checkbox"/> None <input type="checkbox"/> Other _____
<small>(please specify)</small> |
|--|---|--|

HOUSEHOLD INFORMATION

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

Name	Gender	Ethnicity	Date of Birth	Spouse, Partner or Dependent?	HIV Status	If Dependent, Custody?	Monthly Gross Income	Source of Income	Verification Date
Client				Client					
	M F T		/ /			Y N N/A			
	M F T		/ /			Y N N/A			
	M F T		/ /			Y N N/A			
	M F T		/ /			Y N N/A			
	M F T		/ /			Y N N/A			
	M F T		/ /			Y N N/A			
	M F T		/ /			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
- Other

Sources of Income for household

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

ASSISTANCE INFORMATION

<u>Emergency Assistance</u>	<u>Emergency Housing Assistance</u>
Assistance Amount Requested: \$ _____	Assistance Amount Requested: \$ _____
Due Date or Date of Service: _____	First Day of Month to be Covered _____
<input type="checkbox"/> Insurance Premium <input type="checkbox"/> Medical Co-pays (Rx or Dr Visits) <input type="checkbox"/> Misc. Emergencies (App Fees, CBI, Trash, etc.) <input type="checkbox"/> Phone (Basic current service, \$35 maximum) <input type="checkbox"/> Utilities <input type="checkbox"/> Water/Sewer	Total Rent: \$ _____ <small>(Full rent listed on lease)</small>
Pay To Information:	Pay To Information:
Pay to: _____	Pay to: _____
Address: _____	Address: _____
City, State & Zip: _____	City, State & Zip: _____
Distinguishing Info: _____	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.