CUYAHOGA COUNTY BOARD OF HEALTH
YOUR TRUSTED SOURCE FOR PUBLIC HEALTH INFORMATION

Cleveland TGA Ryan White Part A
Eligibility Application

1) Reason for application ☐ New Client ☐ Annual Recertification

2) Name First _____ **Middle** _____ **Last** _____

3) Date of Birth **4) CAREWare ID**

5) Ethnicity
☐ Hispanic/ Latino/a or Spanish origin
☐ Non-Hispanic/Latino/a or Spanish origin

6) Hispanic Subgroup
If the response to Ethnicity is "Hispanic/Latino/a Origin", select all that apply
☐ Mexican, Mexican American, Chicano/a
☐ Puerto Rican
☐ Cuban
☐ Hispanic, Latino/a or Spanish origin

7) Race
Select all that apply
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White

8) Asian Subgroup
If the response to Race is "Asian, select all that apply
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian

9) Native Hawaiian/Pacific Islander Subgroup
If the response to Race is "Native Hawaiian or Other Pacific Islander," select all that apply
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander

10) Gender
☐ Male
☐ Female
☐ Transgender
☐ Unknown

11) Transgender Status
If the response to Gender is "transgender" select transgender status
☐ Male to Female
☐ Female to Male

12) Sex at Birth
☐ Male
☐ Female

13) Housing Status
☐ Stable Permanent Housing
☐ Temporary Housing
☐ Unstable Housing

14) HIV/AIDS Status
☐ HIV-positive, not AIDS
☐ HIV-positive, AIDS status unknown
☐ CDC-defined AIDS
☐ HIV-negative (affected)
☐ HIV-indeterminate (infants <2 years only)

15) Year of HIV Diagnosis ___ ___ ___ ___

16) Risk Factor for HIV infection
Select all that apply
☐ Men who have sex with men (MSM)
☐ Injection drug user (IDU)
☐ Hemophilia/coagulation disorder
☐ Heterosexual contact
☐ Receipt of transfusion of blood, blood components, or tissue
☐ Mother with/at risk for HIV infection (perinatal transmission)
☐ Risk factor not reported or not identified

A. Residency

Address _____ **City:** _____ **State:** ____ **Zip:**

County_____

Residency Documentation (select one):

☐ Paystub (Issued within the last 60 days) ☐ Unexpired Ohio Driver's License of State ID
☐ Current Lease/Letter from Landlord ☐ Medicaid enrollment documentation with client county and/or address
☐ Current award letter- government benefits/program ☐ Current utility, phone, other bills in client's name
☐ Envelope addressed to client with cancelled postage (within the last 30 days).
☐ Notarized letter from resident providing housing for client stating that client resides at that address.
☐ Other_____

B. Modified Adjusted Gross Income (MAGI)

Income sources in this table are required, but are *not* included in MAGI	
Supplemental Income from Social Security (SSI)	$
Child Support Received, Workers Comp., Monetary Gifts	$

Income Included in MAGI

Income Sources	Monthly Household Amount
Wages, Salaries, Tips, etc.	$
Disability Income from Social Security (SSDI)	$
Retirement income form Social Security (SSA)	$
Other: Specify from List-	$
Other: Specify from List-	$
Total Income[A]=	**$**

Adjustments Subtracted from Income

Adjustment Type	Monthly Household Amount
Alimony Paid	
Tuition and Fees	
Other: Specify from List-	
Total Adjustments[B]=	**$**

Modified Adjusted Gross Income (MAGI)

MAGI Calculation (below): Total Income – Total Adjustments = **Monthly MAGI**

Total Income[A]	Subtract	Total Adjustments[B]	Monthly MAGI*
$	Minus	$	**$**

Federal Poverty Level (FPL)

*Monthly MAGI	Family Size	Federal Poverty Level (FPL)
$		**%**

Income Documentation, Examples Include (select all that apply):

- ☐ Current award letter- government benefits/program
- ☐ Documentation of Medicaid enrollment
- ☐ Paystubs (Two in last 60 days)
- ☐ Self-Employment business records
- ☐ Prison release papers (within last 60 days)
- ☐ Copy of last year's tax return
- ☐ Workers compensation documents
- ☐ Other

Self-Attestation of No Income

I, _____ (name of client) certify that my income was zero for the past ____ months.

How I have supported myself/family while having no income be specific (Required):

_____

_____

_____

C. HIV Status (Initial Eligibility Only)

☐ Confirmed HIV diagnosis (reference CDC guidelines)

☐ Lab results at any time during the client's lifetime that show the presence of the HIV (detectable viral load) that includes the name of the client and testing facility

☐ A letter signed by an M.D. on the physician's letterhead that includes either: 1) A statement that the client is receiving services for HIV/AIDS, or 2) A statement of quantitative viral load.

☐ Preliminary Positive

D. Insurance Status

Insurance Status Documentation- Select all that apply

☐ Private- Employer ☐ Private- Individual ☐ Medicare ☐ Medicaid, CHIP, or other public plan

☐ Veterans Health Administration (VA), military health care (TRICARE), and other military health care

☐ Indian Health Service ☐ No Insurance/Uninsured ☐ Other

E. Certification

Client Attestation:

The information provided in this application is true and accurate to the best of my knowledge. Any unreported income or insurance coverage may result in the loss of eligibility.

Today's Date

Client Printed Name_____

☐ *By checking this box, the professional (medical or non-medical case manager) is assuring that the client named on this document has verbally stated that all of the information above is correct. The client is not able to provide their signature due to application being completed virtually or over the phone.*

Ryan White Agency:

Staff Name (Printed)_____ Date: _____

Staff Signature_____ Phone Number

Date Eligibility Established **Date Eligibility Expires**