POLICY AND PROCEDURE	
SUBJECT/TITLE:	Eligibility for Columbus TGA Ryan White Part A Services
SCOPE:	Any professional authorizing clients for eligibility into the Columbus TGA Ryan White Part A program
CONTACT PERSON:	Sean Hubert, Ryan White Director
ORIGINAL DATE ADOPTED:	November 1, 2014
LATEST EFFECTIVE DATE:	March 1, 2019
REVIEW/REVISION DATE(S):	February 28, 2017, July 24, 2018, March 1, 2018
REVIEW FREQUENCY:	Every Five Years
TOTAL # OF PAGES:	7

PURPOSE

The intent of this document is to provide eligibility requirements for the Columbus Transitional Grant Area (TGA) Ryan White Part A program, including defining the eligibility period, documentation, and record maintenance and retention.

POLICY

The Columbus TGA Ryan White Part A program requires individuals receiving services through the program shall:

- have a diagnosis of HIV/AIDS;
- reside within the Columbus TGA (Delaware, Fairfield, Franklin, Licking, Madison, Morrow, Pickaway, or Union county);
- be low-income, as defined as less than 500% of the Federal Poverty Level (FPL).

Eligible clients may have health insurance through public or private sources. Ryan White services are available to meet unmet medical and social support needs, as the payer of last resort.

The Columbus TGA Ryan White Part A program eligibility period begins the date eligibility paperwork is signed by the professional and ends six months from the beginning date. To avoid disruption of care and services, a thirty (30) day grace period is granted before and following the eligibility beginning and expiration dates in which the client may continue to receive services. In the event eligibility paperwork is not certified by the end of the grace period, closure paperwork should be completed, if appropriate. Eligibility must be reassessed at least every six months.

Eligibility forms shall be faxed or securely emailed to Columbus Public Health within two business days of eligibility determination. Client eligibility data, including recertification, must be submitted and maintained in CAREWare. Records must be retained for seven years by the organization of employment for professionals certifying or recertifying clients into the Ryan White Part A program.

BACKGROUND

Columbus Ohio's Ryan White Part A program is funded by the Health Resource and Services Administration (HRSA) to prevent the spread of HIV by assuring that HIV-positive individuals are linked to and retained in medical care for the purpose of achieving viral suppression. Medical and support services are available to eligible individuals through this program. HRSA has established policies to guide grantees, including Columbus Public Health, on their eligibility process,

but grantees (Columbus Public Health) are responsible for further defining and enforcing enrollment and eligibility policies. Per HRSA requirements, to maintain eligibility for Columbus TGA Ryan White Part A services, clients must be recertified every six months. The primary purpose of the recertification process is to ensure that an individual's residency, income, and insurance statuses continue to meet the Columbus TGA Ryan White Part A eligibility requirements. Grantees (Columbus Public Health) have flexibility with regard to timing and process, especially in consideration of health insurance marketplace enrollment periods. Ideally the recertification process is aligned with recertification for OHDAP, Medicaid, and other public or private health insurance enrollments to ensure that client needs are being met in the most streamlined and client-centered manner.

By statute, Columbus TGA Ryan White Part A program funds may not be used for any item or service "for which payment has been made or can reasonably be expected to be made" by another payment source (Sections 2605(a)(6), 2617(b)(7)(F), 2664(f)(1) and 2671(i) of the Public Health Service (PHS) Act). However, these funds may be used to complete coverage that maintains people living with HIV/AIDS in care when the client is either underinsured or uninsured for a specific allowable service, as defined by the Columbus TGA Ryan White Part A program. Reasonable efforts must be made to secure funds other than Ryan White Part A funds whenever possible for services to individual clients. Professionals are expected to vigorously pursue eligibility for other funding sources (*e.g.*, Medicaid, CHIP, Medicare, other state-funded HIV/AIDS programs, employer-sponsored health insurance coverage, and/or other private health insurance, etc.) to extend the finite Columbus TGA Ryan White Part A grant resources to new clients and/or needed services.

GLOSSARY OF TERMS

Eligibility is a determination that an individual is allowed to access services.

Enrollment is participation in a specific service.

Federal Poverty Level (FPL) is a measure of income issued every year by the Department of Health and Human Services that is used to determine eligibility for certain programs and benefits, including Ryan White Part A.

Grantee is Columbus Public Health, Clinical Division, Sexual Health Promotion, Ryan White Part A program.

Health Resource and Services Administration (HRSA) is the federal administrator of the Ryan White grant to Columbus Public Health.

Household income is equal to the Modified Adjusted Gross Income (MAGI) of all individuals in the tax filing unit, including the MAGI for each individual in the tax filing unit required to file separately (*e.g.,* for a family with a youth who earns enough money to require a separate tax filing who is ALSO listed on his/her parents taxes as a dependent, must add their two incomes together to determine MAGI).

Modified Adjusted Gross Income (MAGI) is used to determine eligibility for a variety of federal tax benefits, including eligibility for Ryan White program services. MAGI excludes veteran's benefits, child support, worker's compensation, gifts or inheritances, pre-tax contributions (*i.e.,* childcare costs, retirements savings, etc.), and Social Security benefits, including survivor and disability benefits.

Professional is an individual employed by an agency.

Transitional Grant Area (TGA) is the area served by Columbus Ohio, which includes Delaware, Fairfield, Franklin, Licking, Madison, Morrow, Pickaway, and Union counties.

PROCEDURES & STANDARD OPERATING GUIDELINES

I. The Columbus TGA Ryan White Part A program eligibility period begins the date the eligibility paperwork is signed by the professional and ends six months from the beginning date. To avoid disruption of care and services, a thirty (30) day grace period is granted before and following the eligibility beginning and expiration dates in which the client may continue to receive services. In the event eligibility paperwork is not certified by the end of the grace period, closure paperwork should be completed, if appropriate. Eligibility must be reassessed at least every six months.

II. Every client eligible for the Columbus TGA Ryan White Part A program must have documentation of client eligibility in the client record to verify:

A. HIV-positive status. Acceptable documentation includes:
   1. Copy of a Counseling, Testing, and Referral (CTR) or other Clinical Laboratory Improvement Amendments (CLIA) certified laboratory report of an HIV-positive test result;
   2. Documentation confirming HIV-positive status in Ohio Disease Reporting System (ODRS);
   3. Official paperwork from a physician or advanced nurse practitioner confirming client's HIV-positive status;
   4. Copy of Ohio Department of Health HIV Verification Form, completed by a Disease Intervention Specialist (DIS) or Counseling, Testing, and Referral (CRT) certified professional, verifying HIV-positive status;
   5. Proof of prescription for HIV medication(s); or
   6. Exception Form submitted to and approved by Columbus Public Health.

B. Residency status within the Columbus TGA. Acceptable documentation includes:
   1. Copy of state issued identification card or driver's license;
   2. Copy of mail from a utility or service providing company that confirms client's residency;
   3. Copy of mail from a government agency that confirms client's residency;
   4. Copy of a lease or mortgage statement that lists the client;
   5. Copy of a current pay stub that lists the client's residency;
   6. A professional's verification letter following a visit to the client's home;
   7. A signed letter from a homeless service provider verifying homelessness;
   8. A signed letter, including contact information, from person providing housing indicating client resides at address;
   9. Signed attestation by client confirming residency (may be utilized only one time in a twelve-month period) (See Appendix B);
   10. Signed homeless declaration form by client confirming residency (may be utilized only one time in a twelve month period) (see Appendix C); or
   11. Exception Form submitted to and approved by Columbus Public Health.

C. Low-Income status, which is defined as less than 500% FPL using the MAGI methodology. Acceptable documentation includes:
   1. Copy of the most current IRS Tax Transcript (three (3) years of tax transcripts if self-employed);
   2. Completed MAGI Worksheet (See Appendix D) with a copy of four (4) consecutive weeks of pay stubs;
   3. Completed MAGI Worksheet with letter from employer stating earnings;
   4. Completed MAGI Worksheet with copies of court orders for alimony or other court-ordered payments, excluding child support;
   5. Completed MAGI Worksheet with copies of award letters for benefits from federal, state or county entitlement programs;

6. A signed attestation by the client stating their income, including if the client has no income (may be utilized only one time in a twelve-month period) (See Appendix E); or
7. Exception Form submitted to and approved by Columbus Public Health.

III. Eligible clients may have insurance through public or private sources.

A. Clients with health insurance may or may not have completely adequate coverage. Acceptable documentation includes:
   1. Copy of current insurance card;
   2. Proof that the service is not covered by other third party insurance programs (Military Veterans with VA benefits are eligible for Ryan White Services); or
   3. Exception Form submitted to and approved by Columbus Public Health.

B. Clients without health insurance must apply within three months for health insurance programs for which they may be eligible, including Medicaid, Medicare, Private, Employer-Based Insurance, and/or the Federal Marketplace. Applications should be submitted during open enrollment periods or within the parameters defined for life-changing events. Acceptable documentation of insurance status includes:
   1. Signed attestation from a professional stating the client is not eligible for health insurance coverage (See Appendix F);
   2. Copy of pending application, if potentially eligible;
   3. Signed attestation that the client was informed of health insurance coverage options and the benefits of applying for health insurance coverage, but opted not to apply. Ryan White services shall not be denied based upon client's informed decision to abstain from health insurance. (See Appendix G); or
   4. Exception Form submitted to and approved by Columbus Public Health.

IV. Documentation of client eligibility for the Columbus TGA Ryan White Part A program shall be submitted to Columbus Public Health.

A. Completed Ryan White Part A eligibility paperwork (*e.g.,* Ryan White Part A Eligibility Form—Initial Assessment or Ryan White Part A Eligibility Form—Six Month Review) must be submitted to Columbus Public Health via fax (614.645.8873) or secure email (sexualhealth@columbus.gov) within two business days of the eligibility certification.

B. The Initial Assessment Form (See Appendix H) shall be completed for new Ryan White Part A clients.

C. The Six Month Review Form (See Appendix I) shall be completed every six months for clients who will continue to receive Ryan White Part A services.

V. All Columbus TGA Ryan White Part A program certified and/or recertified client records shall be retained for a minimum of seven years.

A. Each client certified or recertified into the Columbus TGA Ryan White Part A program shall have an individual file.

B. Columbus TGA Ryan White Part A client files may be maintained with other service files, such as medical case management files, non-medical case management files, or health records.

C. Columbus TGA Ryan White Part A client files may be maintained in a paper or electronic format.

D. Columbus TGA Ryan White Part A client files shall be made available to Columbus Public Health upon request for the purpose of program monitoring or program auditing.

VI. The Columbus TGA Ryan White Part A program recognizes that circumstances may render the need for individual exceptions to the eligibility policy.

A. All professionals requesting an exception on behalf of a client are required to submit the Eligibility Exception Form (See Appendix J). The Form must be completed in its entirety and requires the signature of a medical

case manager, non-medical case manager—support or Linkage to Care coordinator and should be submitted via secure email to ANRay@columbus.gov, attention Ryan White Part A Eligibility Exception.

B. Eligibility exceptions are considered for clients who are/have:
   1. Zero income;
   2. Significant safety or confidentiality concerns;
   3. Homeless;
      i. Exception request for clients who are homeless, e.g. live in a hotel/motel, shelter, abandoned building, car, campground, street, must include documentation indicating reason for lack of documentation of proof of residency along with general area and zip code of where the client resides.
   4. Other documentation to show eligibility than what is listed in the policy; and
      i. Exception requests for clients who have other documentation to show eligibility than what is listed in the policy must submit the other documentation with the Eligibility Exception Form.
   5. Other – if a description of the other circumstance is documented.

C. Columbus Public Health will review all submitted eligibility exception requests.
   1. Each exception request is handled on an individual basis.
   2. An email response with a decision or a request for additional information will be provided to the requesting medical case manager, non-medical case manager—support, or Linkage to Care coordinator within two business days.
   3. A copy of the request form, along with the written decision by Columbus Public Health, should be maintained in the client's file.
   4. An approved exception is valid for six months.
   5. The client's need should be re-evaluated at the time of recertification. If there continues to be a need for an exception, the medical case manager, non-medical case manager—support, or Linkage to Care coordinator may submit a subsequent request to Columbus Public Health.

CITATIONS

N/A

CONTRIBUTORS

The following people contributed to the authorship of this document:

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APPENDICES

Appendix A:	Required Documentation Table
Appendix B:	Residency Attestation
Appendix C:	Homeless Declaration
Appendix D:	MAGI Worksheet
Appendix E:	Income Attestation
Appendix F:	Health Insurance Eligibility Attestation
Appendix G:	Health Insurance Attestation
Appendix H:	Columbus Public Health Ryan White Part A Eligibility Form—INITIAL ASSESSMENT
Appendix I:	Columbus Public Health Ryan White Part A Eligibility Form—SIX MONTH REVIEW
Appendix J:	Eligibility Exception Form

REFERENCE FORMS

N/A

SIGNATURES

I have reviewed this document and endorse it as the Eligibility for Columbus TGA Ryan White Part A Services Policy and Procedure:

Not appointed at this time _____ / / _____
Name *Date*
Planning Council Chair

Lynn Kidd _____ 4/26/19
Lynn Kidd *Date*
Planning Council Chair

_____ 07/26/19
Terence Theis *Date*
Planning Council Chair

Sean Hubert _____ 2/26/19
Sean Hubert *Date*
Ryan White Director

Appendix A: Required Documentation Table for Eligibility

REQUIRED DOCUMENTATION TABLE	
HIV-Positive Status*	• Copy of a Counseling, Testing, and Referral (CTR) or other Clinical Laboratory Improvement Amendments (CLIA) certified laboratory report of an HIV-positive test result; • Documentation confirming HIV-positive status in Ohio Disease Reporting System (ODRS); • Official paperwork from a physician or advanced nurse practitioner confirming client's HIV-positive status; • Copy of Ohio Department of Health HIV Verification Form, completed by a Disease Intervention Specialist (DIS) or Counseling, Testing, and Referral (CTR) certified professional, verifying HIV-positive status; • Proof of prescription for HIV medication; or • Exception Form submitted to and approved by Columbus Public Health. ***Documentation collected ONLY with Ryan White Part A Eligibility Form—Initial Assessment.**
Residency Status	• Copy of state issued identification card or driver's license; • Copy of mail from a utility or service providing company that confirms client's residency; • Copy of mail from a government agency that confirms client's residency; • Copy of a lease or mortgage statement that lists the client; • Copy of a current pay stub that lists the client's residency; • A professional's verification letter following a visit to the client's home; • A signed letter from a homeless service provider verifying homelessness; • A signed letter, including contact information, from person providing housing indicating client resides at address; • Signed attestation by the client confirming residency (may be utilized only one time in a twelve-month period)*; • Signed homeless declaration form by client confirming residency (may be utilized only one time in a twelve-month period)* or • Exception Form submitted to and approved by Columbus Public Health. ***A signed attestation by the client confirming residency may be utilized only one time in a twelve-month period, *i.e.*, if an attestation is collected with the Ryan White Part A Eligibility Form—Initial Assessment, it may not be collected with the next Six Month Review or if it is collected with a Six Month Review, it may not be collected with the following Six Month Review.**
Income Status	• Copy of most current IRS Tax Transcript (three (3) years of tax transcripts if self-employed); • Completed MAGI Worksheet with a copy of four (4) consecutive weeks of pay stubs; • Completed MAGI Worksheet with letter from employer stating earnings; • Completed MAGI Worksheet with copies of court orders for alimony or other court-ordered payments, excluding child support; • Completed MAGI Worksheet with copies of award letters for benefits from federal, state or county entitlement programs; • A signed attestation by the client stating their income, including if the client has no income (may be utilized only one time in a twelve-month period)*; or • Exception Form submitted to and approved by Columbus Public Health. ***A signed attestation by the client stating their income, including if the client has no income, may be utilized only one time in a twelve-month period, *i.e.*, if an attestation is collected with the Ryan White Part A Eligibility Form—Initial Assessment, it may not be collected with the next Six Month Review or if it is collected with a Six Month Review, it may not be collected with the following Six Month Review.**
Additional Documentation: Insurance Status	• Copy of current insurance card; • Proof that the service is not covered by other third party insurance programs (Military Veterans with VA benefits are eligible for Ryan White services); • Signed attestation from a professional stating the client is not eligible for health insurance coverage; • Copy of pending application, if potentially eligible; • Signed attestation that the client was informed of health insurance coverage options and the benefits of applying for health insurance coverage, but opted not to apply (Ryan White services shall not be denied based upon client's informed decision to abstain from health insurance); or • Exception Form submitted to and approved by Columbus Public Health.

Appendix B

Client Attestation of Residency

I, _____, swear or affirm that I currently reside in the Columbus Transitional Grant Area, which includes Delaware, Fairfield, Franklin, Licking, Madison, Morrow, Pickaway, and Union counties.

I am aware that providing false, incomplete or inaccurate information regarding my residency may result in my inability to receive further assistance from the Ryan White Part A Program.

_____ _____

Client Signature Date

Appendix C: Homeless Declaration

THE CITY OF COLUMBUS
ANDREW J. GINTHER, MAYOR
COLUMBUS PUBLIC HEALTH

Ryan White Part A
HOMELESS DECLARATION FORM

Date: _____/_____/_____

1. Client Information

First Name: _____ **Last Name:** _____

Date of Birth: _____/_____/_____

2. Declaration of Homelessness

I declare that I currently reside in the Columbus Transitional Grant Area, which includes Delaware, Franklin, Licking, Madison, Morrow, Pickaway, and Union counties, and that I meet one of the following conditions of homelessness:

☐ Live in a hotel, motel, or weekly rate housing

☐ Live in a shelter (family, youth, men's, women's, or domestic violence, or transitional housing)

☐ Live in a car, street/land, campground, or an abandoned building

☐ Other: _____

☐ Other (Please List) _____

General area and zip code of current residence: _____

I am aware that providing false, incomplete or inaccurate information regarding my residency may result in my inability to receive further assistance from the Ryan White Part A Program.

_____ _____/_____/_____
Signature Date

Appendix D: MAGI Worksheet

THE CITY OF COLUMBUS
ANDREW J. GINTHER, MAYOR
COLUMBUS PUBLIC HEALTH

MAGI Worksheet

Only for use with applicants who have not filed a Tax Return for the most recent Tax Year

**Income types listed in ALL CAPS are not calculated in MAGI, but are required fields*
^For any income losses, enter negative $ amount

Client Name: _____ DOB: ____ / ____ / ____

Income Sources Total Monthly $ Amount for all Legal Household Members				
	COLUMN 1		COLUMN 2	
Wages, Salaries, Tips, etc.		Pensions & Annuities (Veteran/Employer Based Pensions, Retirements, or Disability)		
Taxable Interest				
Tax Exempt Interest		Rental Real Estate, Partnerships, S Corporations, Trusts, etc.		
Ordinary Dividends		Farm Income or Loss^		
Taxable Refunds of State/Local Income Taxes		Unemployment Income		
Alimony or Other Spousal Support Received		Retirement Income from Social Security (SSA)		
Business Income/Loss^		Disability Income from Social Security (SSDI)		
Capital Gain/Loss^		SUPPLEMENTAL INCOME FROM SOCIAL SECURITY (SSI)*	Specialty Line A	
Other Gains/Losses^		Other Income (Jury Duty Pay, Gambling Winnings)		
IRA Distributions–Taxable Amount		CHILD SUPPORT RECEIVED, WORKERS COMP, MONETARY GIFTS*	Specialty Line B	
COLUMN 1 Total:	$ -	**COLUMN 2 Total:**	$ -	
TOTAL INCOME = *(COLUMN 1 Total + COLUMN 2 Total):*	**$0.00**			

Non-MAGI (Not calculated, but required) Total Monthly $ Amount for all Legal Household Members			
	COLUMN 3		COLUMN 4
Educator Expenses		Penalty on Early Withdrawal of Savings	
Business Expenses		Alimony Paid	
Health Savings Account		IRA Deduction	
Moving Expenses		Student Loan Interest Deduction	
Deductible Part of Self Employment Tax		Tuition and Fees	
Self Employed SEP, SIMPLE Plans		Domestic Production Activities	
Self Employed Health Insurance Deduction			
COLUMN 3 Total:	$ -	**COLUMN 4 Total:**	$ -
Total Adjustments *(COLUMN 3 Total + COLUMN 4 Total)*	**$0.00**		
Add Specialty Line A	**$0.00**		
Add Specialty Line B	**$0.00**		
NON-MAGI SUBTOTAL = *(Total Adjustments + Specialty Line A + Specialty Line B)*	**$0.00**		

Modified Adjusted Gross Income (MAGI)	
TOTAL INCOME – NON-MAGI SUBTOTAL =	**$0.00**

Notes:

Client Signature _____ Date _____

(Signature, Date and Supporting Documentation is also required)

Appendix E

Client Attestation of Income

I, _____, swear or affirm that I currently receive $_____ in monthly income. I understand that income includes all money received, from work, even that which is not reported for tax purposes. Income also includes, but is not limited to, money received from retirement, investments, unemployment compensation, and disability benefits. I am aware that I must also report any and all income earned by a spouse (if married) and legal guardian (if dependent).

I am aware that providing false, incomplete or inaccurate information regarding income may result in my inability to receive further assistance from the Ryan White Part A Program.

_____ _____

Client Signature Date

Appendix F

Health Insurance Eligibility Attestation

I, _____, affirm that _____
Professional Name *Client Name*

is not eligible for health insurance coverage.

_____

Professional (Signature)
Name and Date

Appendix G

Health Insurance Attestation

I, _____, was informed by _____ that Ryan White is a payer of last resort program. Thus, I was informed that I should apply for a health insurance program that could pay for my HIV-related medical costs. I understand that applying for such a program could provide additional coverage for me, including comprehensive primary and hospital associated costs. Ryan White cannot pay these costs, and I might get billed for them. With this information, I decline health insurance and choose to request that Ryan White pay for my care.

_____

Client Name and Date (Signature)

_____

Professional (Signature)
Name and Date

Appendix H: Columbus Public Health Ryan White Part A Eligibility Form—INITIAL ASSESSMENT

THE CITY OF COLUMBUS
ANDREW J. GINTHER, MAYOR
COLUMBUS PUBLIC HEALTH

Ryan White Part A Eligibility Form
INITIAL ASSESSMENT

Date of Initial Assessment: _____/_____/_____

1. Client Information

First Name: _____ **Middle Name:** _____

Last Name: _____ **Date of Birth:** _____/_____/_____

Sex at Birth: ☐ Male ☐ Female **Gender Identity:** ☐ Male ☐ Female ☐ Transgender (MTF) ☐ Transgender (FTM)

2. Client Demographics

Race: *(Check all that apply)*
☐ White ☐ Black or African American ☐ American Indian or Alaskan Native ☐ Asian
If Asian, please specify: ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other
☐ Native Hawaiian or Pacific Islander
If Native Hawaiian or Pacific Islander, please specify: ☐ Native Hawaiian ☐ Samoan ☐ Guamanian or Chamorro ☐ Other

Ethnicity:
☐ Not Hispanic/Latino(a)
☐ Hispanic/Latino(a)
If Hispanic/Latino(a), please specify: ☐ Mexican, Mexican American, Chicano(a) ☐ Puerto Rican ☐ Another Hispanic, Latino(a) or Spanish Origin ☐ Cuban

3. HIV Status

HIV Status: ☐ HIV-positive, not AIDS ☐ HIV-positive, AIDS status unknown ☐ CDC-defined AIDS

HIV-positive Date: _____/_____/_____

Documentation:
☐ Copy of a CTR or other CLIA certified laboratory report of an HIV-positive test result
☐ Documentation confirming HIV-positive status in Ohio Disease Reporting System (ODRS)
☐ Official paperwork from a physician or advanced nurse practitioner confirming client's HIV-positive status
☐ Copy of Ohio Department of Health HIV Verification Form, completed by a DIS or CRT certified professional, verifying HIV-positive status
☐ Proof of prescription for HIV medication
☐ Exception Form submitted to and approved by Columbus Public Health

4. Residency Status

Does the client live in the Columbus TGA? ☐ Yes ☐ No

Zip Code: _____

Documentation:
☐ Copy of state issued identification card or driver's license
☐ Copy of mail from a utility or service providing company that confirms client's residency
☐ Copy of mail from a government agency that confirms client's residency
☐ Copy of a lease or mortgage statement that lists the client
☐ Copy of a current pay stub that lists the client's residency
☐ A professional's verification letter following a visit to the client's home
☐ A signed letter from a homeless service provider verifying homelessness
☐ A signed letter, including contact information, from person providing housing indicating client resides at address
☐ Signed attestation by the client confirming residency (*may be utilized only one time in a twelve-month period*)
☐ Signed homeless declaration form by client confirming residency (*may be utilized only one time in a twelve-month period*)
☐ Exception Form submitted to and approved by Columbus Public Health

5. Income Status

Does the client meet the "low-income" requirement? ☐ Yes ☐ No
Low-income is defined as less than 500% FPL using the MAGI methodology.

Annual Income: $_____ **Household Size: _____** **Federal Poverty Level: _____**

Documentation:
☐ Copy of most current IRS Tax Transcript (three (3) years of tax transcripts if self-employed)
☐ Completed MAGI Worksheet with a copy of four (4) consecutive weeks of pay stubs
☐ Completed MAGI Worksheet with letter from employer stating earnings
☐ Completed MAGI Worksheet with copies of court orders for alimony or other court-ordered payments, excluding child support
☐ Completed MAGI Worksheet with copies of award letters for benefits from federal, state or county entitlement programs
☐ Signed attestation by the client stating their income, including if the client has no income (*may be utilized only one time in a twelve-month period*)
☐ Exception Form submitted to and approved by Columbus Public Health

6. Insurance Status

Does the client have health insurance? ☐ Yes ☐ No

If "YES", indicate primary insurance type:
☐ Private—Employer
☐ Private—Individual
☐ Medicare
☐ Medicaid, CHIP or other public plan
☐ Veterans Health Administration (VA), military health care (TRICARE), or other military health care
☐ Indian Health Service
☐ Other *(not listed above)*

Documentation:
☐ Copy of current insurance card
☐ Proof that the service is not covered by other third party insurance programs (*Military Veterans with VA benefits are eligible for Ryan White services*)
☐ Signed attestation from a professional stating the client is not eligible for health insurance coverage
☐ Copy of pending application, if potentially eligible
☐ Signed attestation that the client was informed of health insurance coverage options and the benefits of applying for health insurance coverage, but opted not to apply (*Ryan White services shall not be denied based upon client's informed decision to abstain from health insurance*)
☐ Exception Form submitted to and approved by Columbus Public Health

7. Ryan White Part A Approval

By signing this form, I verify that all client eligibility information has been properly reviewed and documented per Columbus Public Health policy and that the client is approved to access Columbus Ryan White Part A services.

_____ _____
Printed Name *Organization*

_____ _____/_____/_____
Signature *Date*

Date of next review:	_____/_____/_____

Appendix I: Columbus Public Health Ryan White Part A Eligibility Form—SIX MONTH REVIEW

THE CITY OF COLUMBUS
ANDREW J. GINTHER, MAYOR
COLUMBUS PUBLIC HEALTH

Ryan White Part A Eligibility Form
SIX MONTH REVIEW

Date of Review: _____/_____/_____ | **Date of next review:** _____/_____/_____

1. Client Information

First Name: _____ **Last Name:** _____

Date of Birth: _____/_____/_____

Sex at Birth: ☐ Male ☐ Female **Gender Identity:** ☐ Male ☐ Female ☐ Transgender (MTF) ☐ Transgender (FTM)

2. Residency Status

Does the client live in the Columbus TGA? ☐ Yes ☐ No **Zip Code:** _____

Documentation:

☐ Copy of state issued identification card or driver's license
☐ Copy of mail from a utility or service providing company that confirms client's residency
☐ Copy of mail from a government agency that confirms client's residency
☐ Copy of a lease or mortgage statement that lists the client
☐ A professional's verification letter following a visit to the client's home
☐ A signed letter from a homeless service provider verifying homelessness
☐ A signed letter, including contact information, from person providing housing indicating client resides at address
☐ Signed attestation by the client confirming residency (*may be utilized only one time in a twelve-month period*)
☐ Signed homeless declaration form by client confirming residency (*may be utilized only one time in a twelve-month period*)
☐ Exception Form submitted to and approved by Columbus Public Health

3. Income Status

Does the client meet the "low-income" requirement? ☐ Yes ☐ No

Low-income is defined as less than 500% FPL using the MAGI methodology.

Annual Income: $_____ **Household Size:** _____ **Federal Poverty Level:** _____

Documentation:

☐ Copy of most current IRS Tax Transcript (three (3) years of tax transcripts if self-employed)
☐ Completed MAGI Worksheet with a copy of four (4) consecutive weeks of pay stubs
☐ Completed MAGI Worksheet with letter from employer stating earnings
☐ Completed MAGI Worksheet with copies of court orders for alimony or other court-ordered payments, excluding child support
☐ Completed MAGI Worksheet with copies of award letters for benefits from federal, state or county entitlement programs
☐ Signed attestation by the client stating their income, including if the client has no income (*may be utilized only one time in a twelve-month period*)
☐ Exception Form submitted to and approved by Columbus Public Health

4. Insurance Status

Does the client have health insurance? ☐ Yes ☐ No

If "YES", indicate primary insurance type:

☐ Private—Employer
☐ Private—Individual
☐ Medicare
☐ Medicaid, CHIP or other public plan
☐ Veterans Health Administration (VA), military health care (TRICARE), or other military health care
☐ Indian Health Service
☐ Other *(not listed above)*

Documentation:

☐ Copy of current insurance card
☐ Proof that the service is not covered by other third party insurance programs (*Military Veterans with VA benefits are eligible for Ryan White services*)
☐ Signed attestation from a professional stating the client is not eligible for health insurance coverage
☐ Copy of pending application, if potentially eligible
☐ Signed attestation that the client was informed of health insurance coverage options and the benefits of applying for health insurance coverage, but opted not to apply (*Ryan White services shall not be denied based upon client's informed decision to abstain from health insurance*)
☐ Exception Form submitted to and approved by Columbus Public Health

5. Ryan White Part A Approval

By signing this form, I verify that all client eligibility information has been properly reviewed and documented per Columbus Public Health policy and that the client is approved to access Columbus Ryan White Part A services.

_____ *Printed Name*

_____ *Organization*

_____ *Signature*

_____/_____/_____ *Date*

Appendix J: Columbus Public Health Ryan White Part A Eligibility Exception Form

THE CITY OF COLUMBUS
ANDREW J. GINTHER, MAYOR
COLUMBUS PUBLIC HEALTH

Ryan White Part A
ELIGIBILITY EXCEPTION FORM

Please fax to Columbus Public Health at 614.645.0746
Attention: Ryan White Part A Eligibility Exception

Date of Request: _____/_____/_____

☐ **Initial Request**

☐ **Request Renewal**

1. Client Information

First Name: _____ **Last Name:** _____

Date of Birth: _____/_____/_____

2. Reason for Exception *(Check all that apply)*

☐ Zero income

☐ Significant safety or confidentiality concern

☐ Homeless (living in a hotel/motel, shelter, abandoned car, campground, street), must include reason for lack of documentation of proof of residency along with general area and zip code of where the client resides

☐ Other documentation to be used to show eligibility than what is listed in the policy

☐ Other (Please List) _____

3. Exception Request Description *(Please provide additional information that will help justify the need for an exception)*

_____

_____

_____

_____

4. Exception Request Sign-Off

Name of Professional: _____

Email Address: _____

Phone Number: _____

Signature of Professional: _____

CPH Office Use Only:

Request Approved: ☐ Yes ☐ No ☐ More information needed

Notes:

_____

_____

_____

Date of Decision Notification: _____/_____/_____