

Date of Initial Assessment: _____

1. Client Information

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

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

Contact Phone Number(s): _____

E-mail Address: _____

Preferred Method(s) of contact: Call Text (if applicable) **Service Carrier** _____ E-mail Letter

May confidential messages be left on voicemail? Yes No

• **If YES: What information can we leave?** Name only Number only Agency Information All Information

What is the best time of day to reach you? _____

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 Native Hawaiian or Native Pacific Islander

If Asian, please specify: Asian Indian Chinese Filipino Japanese
Korean Vietnamese Other

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
- 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 declaration by the client confirming residency
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.

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

Documentation:

- Copy of most current IRS Tax Transcript (three (3) years of tax transcripts if self-employed)
- Copy of four (4) consecutive weeks of pay stubs
- Letter from employer stating earnings
- Copies of court orders for alimony or other court-ordered payments, excluding child support
- Copies of award letters for benefits from federal, state or county entitlement programs
- Signed declaration by the client stating their income, including if the client has no income
- 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*)
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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 declaration 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:
