

Primary Pharmacy:

Name: _____ Phone: (____) ____ - _____

Address: _____

INSURANCE INFORMATION

Primary Insurance Type (may mark more than one): No Insurance Private - Individual Private - Employer
 Medicare Part A/B Medicare Part D Medicare (Part unspecified) Medicaid VA, Other Military IHS
 Other (specify) _____

Additional Insurance Questions: Is insurance through the Health Insurance Exchange (ACA) Yes No

If you have insurance, what is the name of the of the insurance company and plan: _____

Does your health insurance cover medications? Yes NoIf Yes, is there a total expense limit for medications? Yes No

If insurance is through previous employer, date COBRA Coverage began: ____/____/____

Have you applied for Medicaid? Yes No If Yes, Applied Date: ____/____/____**FINANCE INFORMATION****Annual Gross Household Income:** _____**Individual Annual Gross Income:** _____**Household/ Family Size:** _____*(For state office use only)*

____ Percent Poverty Level

 Copy of Income Documentation Copy of Photo Identification Copy of Insurance Card (front and back)**HOUSING STATUS****Most Recent/Current Housing Status:** Stable/ Permanently Housed Institution Unstable Temporary _____

Please indicate information has been gathered and shared by having client initial the appropriate box.

Informational Forms (client provided copies and time for questions & answers):**Client's Initials***Client Rights and Responsibilities**Complaint Grievance Procedures**What You Need to Know About Idaho Laws on HIV**Acknowledgement of Notice of Privacy Practices (agency specific)**Other:***Client Acknowledgement:**

As a partner in this process, I acknowledge that:

- 1) The above information is true to the best of my knowledge (____).
- 2) The purpose of my participation in medical case management is to assure my engagement in HIV medical care (____).
- 3) I will notify my medical case manager of any change in my health insurance status, financial situation, income, or living arrangements (____).
- 4) I authorize this agency to share information and to coordinate care with the Ryan White Part B and Part C programs (____).
- 5) This program involves the receipt of federal and/or state funds; any person supplying false information is subject to state and/or federal criminal prosecution, which may result in fines, imprisonment, or both. Additionally, there will be an automatic six month suspension from RWPB Programs and ADAP (____).

Client/Guardian Signature_____
Date_____
Medical Case Manager Signature_____
Date

Idaho RW MCM Recertification

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