RYAN WHITE PART A ELIGIBILITY APPLICATION

PART 1: APPLICANT INFORMATION

CHECK IF YOU ARE HIV POSITIVE: ☐ YES ☐ NO ☐ UNKNOWN
(PLEASE PROVIDE A COPY OF HIV LAB TEST THAT SHOWS STATUS)

Date:	Ryan White Number (If have one):	
First Name:	Middle:	Last Name:
Date of birth:	☐ Male ☐ Female ☐ Transgender	Gender at Birth:
Race ☐ Asian ☐ American Indian or Alaskan Native ☐ Black or African American ☐ White ☐ Native Hawaiian or Pacific Islander ☐ Other _____	Ethnicity ☐ Hispanic ☐ Not Hispanic	Language Spoken:

Are you pregnant? ☐ Yes ☐ No ☐ Don't know

PART 2: LIVING ARRANGEMENTS

Do you have a housing need? ☐ Yes ☐ No	Do you rent or own? ☐ Rent ☐ Own	Monthly Payment: $

Address where you currently live

Street Address:

City:	State:	Zip:

County:

Mailing Address (if different)

Street Address:

City:	State:	Zip:
Home Telephone:	Work:	Other Contact:

Email:

How many adults live with you? _____ How many children live with you? _____ (under 18 years of age)

How do you prefer to be contacted? ☐ Home Phone ☐ Work Phone ☐ Other Contact Phone ☐ Mail
☐ Email _____ ☐ Other (specify)_____

PART 3: MEDICAID AND OTHER INSURANCE PROGRAMS

Do you have an existing health insurance policy: ☐ Yes ☐ No

If yes, Provide name of insurance company:

If no, does your employer offer health insurance as a benefit? ☐ Yes ☐ No	If no, do you have proof from employer that insurance is not provided? (Proof shown) ☐ Yes ☐ No

Are you taking prescription drugs? ☐ Yes ☐ No If yes, please list:

Screening for other programs:
Please check if you are participating in one of the following programs; and bring the award letter, eligibility letter or card as proof.
☐ Medicaid ☐ Medicare ☐ Supplemental Nutrition Assistance Program (SNAP)
☐ Temporary Assistance for Needy Families (TANF) ☐ Women, Infants, and Children (WIC)
☐ Other:

Do you have a Case Manager? ☐ Yes ☐ No

Name:	Agency:	Phone: 904-508-0710

RYAN WHITE PART A ELIGIBILITY APPLICATION

PART 4: HOUSEHOLD MONTHLY INCOME (GROSS INCOME)

Skip Part 4 If you have proof of eligibility for one of the above programs.

Are you a veteran? ☐ Yes ☐ No	Are you receiving veteran's benefits? ☐ Yes ☐ No

Household Income means gross income from all sources received by the applicant and the applicant's spouse (if married).

Name (First and Last)	Relationship of person to you	Monthly Work Income	Monthly Social Security	Monthly SSI Retirement Income	Unemployment, Child support, public assistance, other	Monthly Totals	Check if no income:
	Applicant						☐
							☐
							☐
							☐
							☐
							☐

If "no income" is checked: provide a statement as to how food, clothing, and shelter are being provided to you.	**Total Monthly Household Income:**

Do you have a checking account? ☐ Yes ☐ No	If yes, what is your current balance?
Do you have a savings account? ☐ Yes ☐ No	If yes, what is your current balance?
Name of Employer(s):	
Are you self-employed? ☐ Yes ☐ No	If yes, what type of business?
Business Street Address:	

City:	State:	Zip:

PART 5: RIGHTS AND RESPONSIBILITES

Initial each item shown.

	I understand that I am responsible for giving truthful and correct information on this application to the best of my knowledge. Failure to be truthful may prevent or delay a determination of eligibility to receive services.
	I understand that if I knowingly give information that is not true or withhold information and receive services that I am not eligible to receive, I may be lawfully punished and have to reimburse the Provider for services.
	I understand the information I provide may be verified that may include computer matching, and the information I give about my income may be checked.
	I understand that the information will be kept confidential in accordance with Florida and Federal law.
	I understand not all services I am eligible to receive may be available, accessible, or funded; and I may not meet specific program qualifications for some programs.
	I understand that at any time during the application process, I can be denied eligibility if my actions are uncooperative, disruptive of office procedures, threatening or hostile toward staff.
	I understand that the staff cannot discriminate because of race, color, sex, age, disability, religion, nationality, or political beliefs.
	I understand that I have the right to ask for a fair hearing if I think the decision of my case was unfair or incorrect.

SIGNATURES

Signature of applicant:	Date:

FOR ELIGIBILITY STAFF ONLY:
Eligibility Staff: _____
Date Determined Eligible: _____ Date of Appointment: _____
Date Referred to: Case Management _____ ADAP _____ Other _____
Date Determined Ineligible: _____ Date of Supervisory Review: _____
Fair Hearing Information was provided: ☐ Yes ☐ NO

ELIGIBILITY STAFF ASSESSMENT WORKSHEET

Date:		Ryan White Number (if have one):
First Name:	Middle:	Last Name:
☐ Male ☐ Female ☐ Transgender		Gender at birth:
Name of Agency: CAN Community Health		Address: 4615 Philips Hwy Jacksonville FL 32207
Eligibility Staff:		Phone Number: 904-508-0710

PROOF OF POSITIVITY

Proof of HIV: An applicant must have documentation of a medical diagnosis of HIV disease. A laboratory test documenting confirmed HIV infection is required. Check the appropriate box.

A positive HIV Immunoassay (IA) test result from an initial antibody or combination antigen/antibody (Ag/Ab) test followed by a positive (reactive) HIV-1/2 type-differentiating test (Supplemental IA), qualitative Nucleic Acid Test (NAT)/Nucleic Acid Amplification Test (NAAT), Western Blot or Immunofluorescence Assay (IFA)	☐
A positive qualitative HIV NAT (DNA or RNA) or HIV-1 p24 antigen test	☐
A detectable (quantitative) HIV viral load (undetectable viral load tests are NOT proof of HIV)	☐
An HIV nucleotide sequence (genotype)	☐
PRISM lab results	☐
No documentation – DO NOT PROCEED, APPLICANT IS NOT ELIGIBILE IF NO DOCUMENTATION PROVIDED.	☐

LIVING IN FLORIDA

Living in Florida: An applicant must be living in Florida. Photo ID is not required but encouraged. One form of documentation other than photo ID must be obtained.

☐ No. Do not proceed, Applicant is not eligible.		☐ Yes. Check all applicable items below.	
Driver's License	☐	Voter's Registration	☑
Lease or Mortgage Statement	☐	Utility Bill	☐
Letter of Support	☐	*Other (specify):*	☐

SCREENING FOR OTHER PROGRAMS

Screening for other programs: An applicant cannot be receiving services or be eligible to participate in local, state, or federal programs where the same type service is provided. Check if the applicant is receiving or has been screened by any of the following:

Medicaid	☐	Medically Needy (list share cost) $	☐
Medicare (specify part applicant receives)	☐	Private Health Insurance (list type)	☐
Veterans Benefits	☐	Low Income Subsidy (other help, Medicare Part D)	☐
Other (specify):			☐

INCOME

Income: An applicant must have a low income (Federal Poverty Level below 400%). A client is automatically income eligible if they have current documentation of eligibility (less than six months old) for one of the following programs:

Medicaid	☐	Supplemental Nutrition Assistance Program (SNAP)	☐
Supplemental Security Income (SSI)	☑	Temporary Cash Assistance for Needy Families (TANF)	☑
Women, Infants, and Children (WIC)	☐	Local Indigent Program	☐
Other (specify):			☑

ELIGIBILITY STAFF ASSESSMENT WORKSHEET

HOUSEHOLD SIZE

Determine Household Size: List all household members by their first and last name, their relationship to the applicant, and whether they are counted or not counted in the household size (applicant, spouse, and dependents are always counted in the household size.)

List Names:

How many adult household members are counted (including applicant)?	
How many of the applicant's dependent children are in the home?	
Total Household Size	

HOUSEHOLD MONTHLY INCOME

Household Monthly Income: For applicants and household members only. Determine the applicant's household income and the counted members income named on the application. If the applicant is unemployed, documentation must be provided of other means of support. Complete the list annually or monthly.

Unemployed ☐	Applicant	Counted Members
Employment (where):		
Self Employed:		
Checking Account:		
Investment Income (i.e. Rental Properties):		
Retirement Income (if accessed):		
Disability Benefits:		
Alimony:		
Child Support:		
Other (specify):		
Total Household Income:		

FEDERAL POVERTY LEVEL

Calculating Federal Poverty Level (FPL): Using the most current FPL chart (https://aspe.hhs.gov/poverty-guidelines) from the U.S. Department of Health and Human Services which is updated annually, determine the FPL for the applicant.

Total Household Income:	**Total FPL%:**
The applicant meets the income requirements.	☐
The applicant does not meet the income requirement and is not eligible	☐

ELIGIBILITY

The applicant meets the income requirements	☐	The applicant does not meet the income requirements and is not eligible.	☐

RIGHTS AND RESPONSIBILITIES

Rights and Responsibilities: An applicant must be willing to cooperate with eligibility staff during the eligibility process, and sign and comply with the Rights and Responsibilities established in the application.

The applicant has initialed each requirement in the application, provided the required signature, and complied with the requirements during the eligibility process.	☐
The applicant has no complied with this requirement. Explain:	☐

FINAL DETERMINATION

Final Determination: Based on the eligibility interview, application, and required documentation, the applicant is:

Eligible	☐	Date:
Not Eligible	☐	Date:

Client Eligibility Update Form

Date

Form Completed By:
☒ RWP A
☐ RWP B

Ryan White Part (RWP) A and B programs in Florida require client eligibility to be reviewed and confirmed every year. This Client Eligibility Update Form allows existing clients to submit information to your eligibility or case management agency as required to determine eligibility for the next 12 months.

You must recertify your eligibility every 366 days. This form may be used for the first annual recertification and then alternating years thereafter to recertify client eligibility status.

Client Name:	**Client DOB:**
Phone:	**E-mail:**
Address: *(Please provide your current home address)*	
Since your initial certification or annual recertification one year ago, have you changed your home address?	☐ No, my home address has not changed. ☐ Yes, my home address has changed. *
**If your current home address has changed from your last certification, please provide documentation to determine if this change affects your eligibility for RWP A or B services.*	
Living Arrangement	
Since your initial certification or annual recertification one year ago, has your living arrangement changed? ☐ No, my living arrangement has remained the same. ☐ Yes, my living arrangement has changed. *	Select current living arrangement: ☐ Stable/permanent (own home, renting, HOPWA-funded housing assistance, Section 8 housing, public housing, etc.) ☐ Temporary (transitional housing, temporarily living with family or friends, hotel or motel paid without a voucher, etc.) ☐ Unstable (emergency shelter, hotel or motel paid with a voucher, homeless, prison, jail, etc.)
**If your current living arrangement has changed from your last certification, please provide documentation to determine if this change affects your eligibility for RWP A or B services.*	

Household Income *(Includes income of spouse and dependents, if applicable)*

Current Household Size: _____ Current Household Income: _____

Monthly OR Annually

(circle one)

Since your initial certification or annual recertification one year ago, has your income or household size changed?

☐ No, the income and household size has remained the same.

☐ Yes, the income AND/OR household size has changed. *

**If your current household size and/or income has changed, please provide documentation to determine if this change affects your eligibility for RWP A or B services.*

Insurance Status

Since your initial certification or annual recertification one year ago, has your insurance status changed?

☐ No, my insurance status has remained the same.

☐ Yes, my insurance status has changed. *

Select current insurance status:

☐ Medicaid

☐ Child Health Insurance Program (CHIP)

☐ Medicare (A, B, C or D)

☐ ACA/Marketplace Health Plan

☐ Employer-Sponsored Health Insurance

☐ Other Private Insurance

☐ No Insurance

**If your current insurance status has changed, please provide documentation to determine if this change affects your eligibility for RWP A or B services.*

The information provided by me above is true, accurate and complete to the best of my knowledge. I understand that providing false information may disqualify me from receiving RWP A or B services. I also understand that RWP A and B cannot pay for services that have been paid or can reasonably be paid by any other source (e.g., state, federal or private entity) that provides the same health benefits or services.

Client/Legal Representative Signature: _____ *Date:* _____

Print Client Name: _____

*** In-person certifications must be signed by the client/legal representative and staff. Certifications not made in person (phone, email, mail, etc.) must include the name, signature and agency name of the staff member completing the form. ***

Staff Signature: **Date:**

Staff Name:	**Agency Name:** CAN Community Health	**Phone #:** 904-508-0710

CLIENT RIGHTS, RESPONSIBILITIES AND GREIVANCE PROCEDURES

Date:	**Ryan White Number:**

RIGHTS

You have the right to receive timely, respectful, high quality services from the staff of all providers without regard to age, ethnicity, gender, disability, religion, sexual orientation, values and beliefs, and marital status.
You have the right to request copies of all singed documents and have access to your service record.
You have the right to participate in the development of your plan of care.
You have the right to choose the provider and type of services and care required within the scope of clinical responsibility.
You have the right to receive current information and education about the disease, the medicines, treatment and self-help measures.
You have the right to appeal decisions with which you do not agree and to complete a patient grievance form.
You have the right to request an interpreter to enhance communication.
You have the right to refuse recommended treatment plans as allowed by law based up on the patient/client's judgment of risks and benefits and without pressure or unwanted influence from the health care provider.

RESPONSIBILITIES

You are responsible for conducting yourself in a courteous and respectful manner and also for responding in a timely manner to all appointments. Offensive language, verbal or physical threats, and aggressive behavior will not be tolerated.
You are responsible for keeping all appointments.
You are responsible for notifying the provider of services if any illness interferes with scheduled appointments.
You are responsible for working with your Case Manager to develop a plan of care.
You are responsible for providing all documentation needed to assist in enrolling you in any eligible programs or services.
You are responsible for notifying your Case Manager when you have problems in obtaining services or when you are dissatisfied with your care.
You are responsible for following the instructions of your health care provider to the best of your ability.
You may be responsible for a portion of the costs of your health care services.
You are responsible for notifying your Case Manager of any changes in your address, income, and living arrangements.

GRIEVANCE PROCEDURES

If you are dissatisfied with the services you are receiving, you may voice a complaint or grievance to your Case Manager.
If you are not satisfied with the results of the meeting with your Case Manager, you may, within 30 days, request a hearing with the designated grievance officer of this service provider.
If you are unable to resolve the issue with the grievance officer, you may, within 30 days, file your complaint or grievance in writing to: Ryan White Program Manager, Social Services Division, 1809 Art Museum Drive, Suite 100, Jacksonville, FL 32207.
The Ryan White Program Manager will respond in writing within 14 days of receipt of your grievance or complaint informing you of the time and place of a hearing.
At the hearing, you may be accompanied by a friend, relative, legal counsel or spokesperson. The decision of the hearing officer is final.
I have had the opportunity to discuss and I am fully aware of the Rights, Responsibilities and Grievance Procedures outlines above and I am aware that failure to comply may result in disenrollment from services with this service provider.

Client Signature:	Date:
Case Manager Signature:	Date:

CAREWARE DATA MANAGEMENT SOFTWARE AUTHORIZATION TO SHARE INFORMATION

Date:	**Service Provider Name:** CAN Community Health

By signing below, I _____ (your name) am aware that CAN Community Health (Service Provider Name) is part of a collaborative group of organizations that provide Ryan White CARE Act Part A, Part B, Part C, Part D, and General Revenue/Patient Care Network Services. I agree to allow the Service Provider listed above, the City of Jacksonville, as the Ryan White Part A grantee, the Florida Department of Health – Duval County as the Ryan White Part B grantee, as the data manager and the agencies listed below, to exchange among them, information regarding the year of my HIV positive diagnosis, proof of HIV status, HIV/AIDS disease stage at intake, mode(s) of transmission and TB status at intake.

I understand that this information will be used to appropriately coordinate Ryan White Part A, Part B and General Revenue/Patient Care Network Services provided to me. I also understand this information may be used for linkage to services, billing purposes, quality assurance and contract monitoring activities. It is expressly understood that this information will include identifying and demographic information which includes name, gender, date of birth, address, zip code, guardian (if I am a minor), age, race/ethnic background, primary language, annual income, size of household, country of origin, federal poverty level, number of family members and/or significant other receiving Ryan White funded services. I understand that group level statistical data (not name identification) drawn from this information will be accessed by the funding sources for the purpose of developing necessary reports. Refusal to sign this Authorization to Release information can affect coordination of my care and I will assume financial responsibility for services provided.

I understand that the Jacksonville Area Ryan White Network uses and electronic record keeping database software system called "CAREWare Data Management System" (CAREWare) CAREWare is a computer software program specifically developed to help collect information and coordinate services for people with HIV disease. CAREWare is networked among the organizations listed below to assist Providers in coordinating my care.

I understand that City of Jacksonville will have access to my information for system maintenance and will not be permitted to disclose such information without my written consent.

By signing below, I agree to hold all agencies named in this consent harmless of any liability associated with the release of information as authorized in this consent.

I may revoke this consent at any time by signing the revocation line below or by informing, in writing, the agency holding this original consent form.

I understand that the following statement binds any entity receiving information as a result of this release:
"This information has been disclosed to you for/from records whose confidentiality is protected by State Law. State Law prohibits the below named agencies and any Ryan White Part A, Ryan White Part B and General Revenue/Patient Care Network Provider from making any further disclosure of any such information without the specific written consent of the person to whom such information pertains or as otherwise permitted by State Law. A general authorization for release of medical and non-medical information is not sufficient for this purpose." Section 381.004, Florida State Statutes.

AIDS Healthcare Foundation (AHF)	Gateway Community Services, Inc.
CAN Community Health Inc. (CAN)	Jacksonville Area Legal Aid, Inc. (JALA)
Florida Department of Health – Baker County	Lutheran Social Services of NE FL (LSS)
Florida Department of Health – Clay County	Northeast Florida AIDS Network (NFAN)
Florida Department of Health – Duval County	UF CARES/Rainbow Center
Florida Department of Health – Nassau County	UF Health Jacksonville Medical Center
Florida Department of Health – St. Johns County	Other (specify):

Client or Legal Representative Signature:	**Date:**
Relationship of Client to Legal Representative:	**Ryan White Number:**
Witness Signature:	**Date:**
If Revoking Consent – Date Revoked:	

Note to Receiving Agencies: This information has been disclosed to you from records whose confidentiality is protected by State Law. State Law prohibits you from making any further disclosure of such information without specific written consent of the person to who such information pertains, or as otherwise permitted by State Law. A general authorization is not sufficient for this purpose.

AUTHORIZATION TO RELEASE INFORMATION

Date:	**Service Provider Name:** CAN Community Health

By initialing below, I _____ (your name) authorize CAN Community Health (Service Provider Name) to release and exchange my Protected Health Information, specifically the information initialed below. I understand that I may revoke this authorization at any time, except to the extent that the program has already released it. I also understand that the City of Jacksonville Social Services Division, Ryan White Part A Administrative Agency and the Florida Department of Health Duval County Ryan White Part B, pay for services, and as such, will have access to my HIV status, medical records and social service records for the purpose of providing treatment, finance, operations, auditing, and planning. Failure to release the information shall make me financially responsible for any expenses incurred in medical and non-medical treatment.

Signature of Client/Legal Representative:	Date:
Relationship to Client of Legal Representative:	
Signature Witness:	Date:

PLEASE INITIAL NEXT TO THE FOLLOWING YOU AUTHORIZE TO RELEASE:

	HIV Status		Laboratory Values
	Medications		Prescriptions
	Physician Orders		Substance Abuse Information
	Case Management Records		Financial Eligibility Records
	Physician Progress Notes		Nursing Progress Notes
	Mental Health Information		Other (specify):

I also authorize, the following selected agencies and/or individuals(s) to release and exchange my Protected Health Information specified above:

PLEASE INITIAL NEXT TO THE FOLLOWING YOU AUTHORIZE TO RELEASE:

	AIDS Healthcare Foundation (AHF)		Jacksonville Area Legal Aid, Inc. (JALA)
	Catholic Charities		Lutheran Social Services of NE FL (LSS)
	CAN Community Health Inc. (CAN)		Northeast Florida AIDS Network (NFAN)
	Central Pharmacy (DOH Duval)		Reza Health
	Edgewood Pharmacy		UF CARES/Rainbow Center
	Florida Department of Health – Baker County		UF Health Jacksonville Medical Center
	Florida Department of Health – Clay County		Other (specify):
	Florida Department of Health – Duval County		
	Florida Department of Health – Nassau County		
	Florida Department of Health – St. Johns County		
	Gateway Community Services, Inc.		
	Hope Across the Globe		

All the information I hereby authorize to be shared by or released to or from the specified agencies will be held strictly confidential and may not be re-disclosed by either party without my written consent. I understand that Section 381.004(3) of the Florida Statutes ensures confidentiality of information contained in my medical records.

I understand that this authorization will remain in effect one year from the date signed unless I specify an earlier/later expiration date.

Client Signature:	Date Revoked:
Witness Signature:	Date:

Note to Receiving Agencies: This information has been disclosed to you from records whose confidentiality is protected by State Law. State Law prohibits you from making any further disclosure of such information without specific written consent of the person to who such information pertains, or as otherwise permitted by State Law. A general authorization is not sufficient for this purpose.

CLIENT CONSENT TO FAX CONFIDENTIAL INFORMATION

Date:	**Ryan White Number:**
Last Name, First Name:	Date of Birth:

Florida law requires that information contained in medical records be held in strict confidence and not be released without your written authorization to release certain types of sensitive medical information. Ryan White Network Providers may fax confidential information to a provider or receive faxed information that was request from a Provider with your permission. Faxing such information is voluntary. You will not be denied services based on a refusal to allow your confidential information to be faxed.

Steps will be taken to make sure your information arrives, safely, but faxes can be misdirected.

I _____(Name of Client/Legal Representative), do hereby authorize _____ (Agency or individual in possession of records) _____(address of agency or individual) to fax the following information (Initial any or all that apply):

	STD records		TB records
	HIV/AIDS records		Drug/alcohol treatment records
	Psychiatric/psychological information/records		Adult and child abuse information
	Other (specify):		Other (specify):

The information will be faxed to:

Provider Name (fax recipient):	
Contact Person:	
Provider Phone Number:	
Provider Fax Number:	

Client or Legal Representative Signature:	Date:
Legal Representative Relationship to Client:	
Witness Signature:	Date:

If a Client Withdraws Consent:

Client or Legal Representative Signature:	Date Revoked:
Legal Representative Relationship to Client:	
Witness Signature:	Date:

CONSENT TO SEND ELECTRONIC COMMUNICATION

Date:	**Ryan White Number:**
Last Name, First Name:	

I understand that I am responsible for any fees incurred – standard rates will apply.
This form will be completed at least once a year unless the contact information changes.
I understand that I have the right to change my mind and have this service stopped. I must sign the form below to no longer receive electronic communication.

Check the appropriate organization below:

☐	AHF	☐	Jacksonville Area Legal Aid
☑	CAN Community Health	☐	NFAN
☐	Community Rehabilitation Center	☐	Lutheran Social Services
☐	Department of Health Duval County	☐	River Region
☐	Gateway Community Services	☐	UF CARES
☐			

Contact Information

☐	EMAIL:
☐	CELL PHONE:

SIGNATURES

I **consent** to receive electronic communication from the organization selected above:

Client or Legal Representative Signature:	Date:
Legal Representative Relationship to Client:	

I **DO NOT** give consent to receive electronic communication from the organization selected above:

☐	EMAIL:
☐	CELL PHONE:

Client or Legal Representative Signature:	Date:
Legal Representative Relationship to Client:	

INITIATION OF SERVICES
GENERAL RELEASE AND ACKNOWLEDGEMENT CONSENT

PART 1: CONSENT TO RELEASE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS			
Date:		**Ryan White Number:**	
Last Name, First Name:		Date of Birth:	
Name of Agency: CAN Community Health			
Agency Address: 4615 Phillips Hwy, Jacksonville FL 32207			
I, consent to use and disclosure of Protected Health Information for treatment, payment or health care operations. This includes the release of the following information listed below:			
☑ Medical	☐ Sexually Transmitted Diseases	☐ Alcohol/Drug Abuse	☑ HIV/AIDS
☐ Tuberculosis	☑ Case Management Information	☐ Psychiatric/Psychology	☐ Other:

PART 2: MEDICARE PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE, AND PAYMENT REQUEST
(Only applies to Medicare Clients)
As Client/Representative signed below, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the above agency to release Protected Health Information to the Social Security Administration or its intermediaries/carriers for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician's services to the above named agency and authorize it to submit a claim to Medicare for payment.
PART 3: ASSIGNMENT OF BENEFITS (ONLY APPLIES TO THIRD PARTY PAYERS)
As Client/Representative signed below, I, assign to the above named agency all benefits provide under any health care plan or medical expense policy. The amount of such benefits shall not exceed the medical charges set forth by the approved fee schedule. All payments under this paragraph are to be made to above agency. I am personal responsible for charges not covered by this assignment.

PART 4: SIGNATURES	
By my signature below I verify the above information and receipt of the notice of privacy rights:	
Client or Legal Representative Signature:	Date:
Legal Representative Relationship to Client:	
Witness Signature:	Date:

If a Client Withdraws Consent:	
I, _____withdraw this consent effective _____(date).	
Client or Legal Representative Signature:	Date Revoked:
Legal Representative Relationship to Client:	
Witness Signature:	Date:

4615 Phillips Hwy.
Suite 3
Jacksonville, FL 32207
(904) 508-0710

HIPAA Acknowledgement

I understand that as part of my health care, CAN Community Health, originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand and have been provided with a *Notice of Privacy Policies* (Notice) that provides a more complete description of information uses and disclosures.

I understand that CAN Community Health is not required to agree to restrictions requested. I understand that I may revoke my permission in writing, except to the extent that the organization has already taken action in reliance thereon.

I further understand that CAN Community Health reserves the right to change their notice and policies, in accordance with Section 164.520 of the Code of Federal Regulations. A copy of our current Notice is available upon request.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity; and I consent to such disclosure for these permitted uses, including disclosures via fax.

I authorize CAN Community Health, to release information about my appointments, billing and/or financial information, and medical information to the following individuals:

Check all that apply

☐ **Spouse** ☐ **Parents** ☐ **Children** ☐ **Legal Guardian** ☐ **Grandparents** ☐ **Other**

Name:_____ **Phone #:** _____

Name:_____ **Phone #:** _____

This list may not be all inclusive and I recognize that my healthcare providers may have to use their best judgment in some instances where they communicate to others involved in my care.

Additionally, I authorize CAN Community Health to leave information concerning my appointments, billing or financial information, and medical information on my answering machine/voice mail at the phone number(s) which I have provided. I understand that receiving information regarding my health can be delayed if messages cannot be left.

I understand that in order to revoke the authorizations above (except to the extent that the organization has already taken action), I must request this revocation in writing to the Compliance Officer and that until such written document is received, this authorization will be followed.

Patient Signature	Patient (Print Name)	Date
Guardian's Signature	Print Name & Relationship	Date
Witness Signature	Witness (Print Name)	Date

4615 Phillips Hwy.
Suite 3
Jacksonville, FL
32207

CAN Community Health

Notice of Privacy Practices Acknowledgment Form

Name:_____ ID#: _____

Facility/Site/Program: CAN Community Health

I have received a copy of the Comprehensive Care Center Notice of Privacy Practices Form DH 150-741, 09/13.

Signature: X_____ **Date:** _____
Individual or Representative with legal authority to make health care decisions

If signed by a Representative:

Print Name:_____ Role: _____
(Parent, guardian, etc.)

Witness:_____ Date: _____

If the individual has a representative with legal authority to make health care decisions on the individual's behalf, the notice must be given to and acknowledgment obtained from the representative. ***If the individual or representative did not sign above, staff must document when and how the notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it.***

Notice of Privacy Practices given to the individual on _____
Date

___Face to face meeting
___Mailing
___Email
___Other _____

Reason Individual or Representative did not sign this form:
___Individual or Representative chose not to sign
___Individual or Representative did not respond after more than **one** attempt
___Email receipt verification
___Other _____

Good Faith Efforts: The following good faith efforts were made to obtain the individual's or Representative signature. Please document with detail (e.g., date(s), time(s), individuals spoken to and outcome of attempts) the efforts that were made to obtain the signature. More than **one** attempt must have been made.
___Face to face presentation(s) _____
___Telephone contact(s) _____
___Mailing(s) _____
___Email _____
___Other _____

Staff Signature:_____ **Date:** _____

Print Name:_____ **Date:**_____

CASE MANAGEMENT AND OUTPATIENT AMBULATORY MEDICAL SELECTION FORM

Date:	**Ryan White Number:**
Last Name, First Name:	Date of Birth:

Please select a **Case Management Agency** from the list below. Place your initials by your selection.

Initials	Provider	Address	Phone
	AIDS Healthcare Foundation (AHF)	2 Shircliff Way, Suite 900 Jacksonville, FL 32204	904-381-9651
	Lutheran Social Services	4615 Philips Highway Jacksonville, FL 32207	904-448-5995
	Northeast Florida AIDS Network (NFAN)	2715 Oak Street Jacksonville, FL 32205	904-356-1612
	UF CARES	655 West 8th Street Main Hospital – 3rd Floor Jacksonville, FL 32209	904-244-2120
	Other (Specify):		
	I am not interested in Case Management at this time.		

Please select a **Medical Provider** from the Ryan White Part A Medical Providers available in this area. Place your initials by your selection.

Initials	Provider	Address	Phone
	AIDS Healthcare Foundation (AHF)	2 Shircliff Way, Suite 900 Jacksonville, FL 32204	904-381-9651
	CAN Community Health	4615 Philips Hwy Jacksonville, FL 32207	904-508-0710
	UF CARES	655 West 8th Street Main Hospital – 3rd Floor Jacksonville, FL 32209	904-244-2120
	Other – I am receiving care from outside the Jacksonville TGA Ryan White Part A Network (Please specify):		

As part of my initial intake in the Jacksonville Area Ryan White Part A Network, I have received an explanation of services offered by Ryan White Service Providers. I have selected the provider indicated by my initials for case management and medical provider services and request that these providers assist me in obtaining services for which I may be eligible. I am freely choosing to enroll for services, and have not been offered or promised any gifts or benefits for enrolling in services with these providers.

By my signature below I verify the above information:

Client or Legal Representative Signature:	Date:
Legal Representative Relationship to Client:	
	Date:
Staff Signature:	Date:

RYAN WHITE

Non-Medical Individualized Care

Client Name:	Plan	Last Medical Appt:		
NMCM Name:	Care Plan Timeframe:	Date of Latest Labs:		
Date Completed:	NOE Expiration Date:	CD4:	VL:	

#	Identified Service Need	Service Provider	Goals/Objectives	Realistic Time Frames	Outcome	Barriers (if applicable)
1	Ryan White Eligibility	CAN Community Health	Client will meet with Non-Medical Case Manager every 366 days to be evaluated and assessed for Ryan White Eligibility in accordance with Florida statutes and PCN-21.02.	366 Days	☐	
2	HIV Primay Care		Client will meet with HIV Primary Care provider at least twice annually and follow up with all treatment recommendations provided by this provider.	every 6 months	☐	
3	Ryan White Medical Case Management		Client provided a list of MCM funded agencies and referred to agency of client choice OR Client will follow up with assigned/chosen Ryan White Medical Case Manager for all primary case management needs.	2 days OR As Needed	☐	
4						
5						

Summary of Care (if applicable):

Client Statement: I have participated in the creation of my care plan and understand that I have to take responsibility for my plan in order to succeed. I agree to work on the above stated goals with the assistance of my non-medical case manager.

Client Signature: _____ Date: _____

NMCM Staff Signature: _____ Date: _____

CLIENT FEE ASSESSMENT FORM

Date:		**Ryan White Number:**
First Name:	Middle:	Last Name:
Address:		

Under the Ryan White HIV/AIDS Treatment Extension Act of 2009, clients provided services funded through the Ryan White program must be charged fees for services based on a sliding fee schedule. For those clients whose income is less than or equal to 200% of the official poverty level, no charges will be imposed. For those clients whose income is greater than 100% of the Federal poverty level, fees will be imposed based on the following fee schedule.

Client Fee Group	First Visit per Month	Second Visit Per Month	Subsequent Visits per Month
100% or less	0	0	0
>100% <=200%	0	0	0
>200% <=300%	$1.00	$1.00	$1.00
>300%	$1.00	$1.00	$1.00

Client's Fee Group is:	Client's fee will be:

I understand that documented health care services that I pay for, which are related to my illness and not eligible for payment through Ryan White, will be considered and deducted when determining my overall cost of services through the Ryan White program. I further understand that I am responsible for submitting this documentation to my service provider.

My current income is:

Which is % of the Federal Poverty Level

I am aware that I am assessed a fee of: $1.00

I am able / unable (circle one) to pay the following amount: $1.00

If unable to pay today, I have been informed to make every effort to pay the fee imposed at my next visit. _____ Client Initial

Client Signature:	Date:
Witness Signature:	Date:

Comments:

SLIDING FEE SCALE AND CAP CALCULATOR

Date:	Ryan White Number:
Last Name, First Name:	Date of Birth:

Under the Ryan White HIV/AIDS Treatment Extension Act of 2009, clients provided services funded through the Ryan White program must be charged fees for services based on a sliding fee schedule. For those clients whose individual (not family or household) gross income is less than or equal to 200% of the official poverty level, no charges will be imposed. For those clients whose individual (not family or household) gross income is greater than 200% of the Federal poverty level, annual cumulative charges for HIV services cannot exceed the following limits per income.

☐	Below 100% of poverty, no charge
☐	101% - 200% of poverty, no charge.
☐	201% - 300% of poverty, a limit of 7% of the annual gross income.
☐	301% - 400% of poverty, a limit of 10% of the annual gross income.

2024 HHS Poverty Guidelines

Poverty Level	Florida	Charge
200% or less	0 – $30,270	0
201% - 300%	$30,271 - $45,330	7%
301% - 400%	$45,331 or more	10%

Cap Calculator

Assess individual client income.	Annual Income	$
Identify charge based on individual client income.	% Charge	%
Multiply annual income by % charge to determine cap.	Annual Cap	$
Once cap is reached, no further charges are assessed for the calendar year.		

4615 Phillips Hwy.
Jacksonville, FL 32207
(904) 508-0710

Financial Policy

Medicaid: CAN Community Health. accepts Medicaid.

Managed Care Plans (HMO): CAN Community Health, Inc. files insurance claims for managed care groups in which we participate. These policies often require co-pays. Patients are responsible for that co-pay at the time of service.

Medicare: CAN Community Health, Inc. files insurance claims for Medicare. We accept Medicare allowable amounts as payment. Patients are responsible for charges applied to their deductible, any co-insurance and non-covered charges.

Other Insurance (PPO. POS): Patients are responsible for charges applied to their deductible, any co-insurance, and other non-covered charges.

Self-Pay: All services are required to be paid in full at the time of service.

Summary: We accept payment for covered services from insurance plans in accordance with our contracts. Our patients are responsible for applicable co- insurance and deductible amounts, and for services that are not covered by insurance.

Providing quality medical care for our patients is our primary concern. It is, however, the responsibility of the patients to know and understand their insurance policies and guidelines. **All co-pays and deductibles are due at the time of service.**

******* *********

I understand that I am responsible for the payment of this account, and hereby assume and guarantee payment of all expenses incurred during my office visits. In the event a credit (refund) balance appears on this account, I hereby irrevocably authorize the office to transfer and apply such credit on any outstanding account incurred by me.

I have read and understood the office policy as stated above and agree to accept the responsibility described.

_____ _____

Patient/ Responsible Party Signature Date

CAN Community Health Transportation Service Agreement

Eligibility Criteria, Participation Requirements and Potential Risks

CAN Community Health offers the option to use transportation services with private on-demand transportation companies, for transportation to and from CAN Community Health appointments, or other social or medical services deemed necessary by a CAN Community Health designated employee.

Eligibility Criteria

For eligibility for this service, you must meet all the following criteria:

- Receiving medical, case management, dental or other services from CAN Community Health or other social or medical services deemed necessary by a CAN Community Health designated employee.
- Transportation services cannot be used when alternate transportation is available, including but not limited to family members, neighbor(s), friend(s), public transportation, insurance provided transportation or community agency providing rides.
Transportation services cannot be used if your existing available transportation options do not effectively meet your needs.
- Must be 18 years of age or older.

Participation Requirements

Once you receive initial approval for the service, you must meet the following requirements prior to being able to access on-demand transportation company services for transportation.

- Must be a patient or client of CAN that has reviewed and signed all required documentation (including but not limited to this document).
- Always ride in the vehicle when you request a ride. Other people can ride with you, but you must be riding. If traveling with small children, it is your responsibility to provide the age and size appropriate car seat for your child. The ride cannot be altered to stop at other locations.
- Not have excessive (more than 5) no show or cancellation fees assessed within a 90-day period.
- Follow private on-demand transportation companies' policies.

Ride restrictions:

- Ride must not exceed 45 miles per direction without approval.

Suspension or Revocation of your Participation in the Service

CAN Community Health reserves the right to revoke or suspend your participation in the service for any reasons, including, without limitation, if you violate the participation requirements outlined above. In the event of revocation or suspension, you may remain eligible for transportation services from other service providers, and the designated employee will assist you in finding alternative transportation options.

Potential Risks for You to Consider Before you decide whether to participate in the service

It's important to understand how on-demand transportation services work and what risks there are in using them. You get to decide whether this service is the right fit for you, and you may decide not to participate if you are not comfortable doing so. As with any voluntary service, you can stop participating. You can work with a designated employee to find other transportation options. Notwithstanding anything to the contrary, CAN may discontinue these services at any time.

It is your responsibility to check availability and have back-up transportation in place in case on demand transportation isn't available. CAN Community Health does not control which driver will pick you up on any given day as the service will match your route with an available driver to take you to your destination at the time a ride is requested.

The drivers who provide these rides are not employees of the on-demand transportation service or CAN Community Health. They work for themselves and use their personal vehicles. That means that neither on-demand transportation nor CAN Community Health is legally responsible for the drivers' actions while transporting you in their personal vehicles.

You acknowledge and agree that you assume any and all risk in connection with this Agreement and do hereby waive, indemnify, and forever release CAN Community Health, its officers, directors, employes, and its agents from any and all liability in connection with or in any way relating to this Agreement.

It is important to us that you understand the above information and that you make an informed choice on whether to use the on-demand transportation. If you do not understand or need more information or time to decide if this program is right for you, do not sign below.

By signing below, I acknowledge that I have read this document and that I understand its contents. I am acknowledging that I understand the potential risks of participating in the service and want to participate. If this is signed by a Guardian, the Guardian affirms that she/he/they/them has the authority to sign this document on behalf of his/her/they/them and has discussed the contents with them.

Rider's Name: Signature: Date:

Guardian Name (if applicable): Signature: Date:

CAN Community Health Staff member: Signature: Date:

Your Copy

2024-2025 RW Part A Service Providers

AIDS Healthcare Foundation (AHF)
2 Shircliff Way, Jacksonville, FL 32204
(904) 381-9651

- Outpatient and Ambulatory Medical Care
- AIDS Pharmaceutical Assistance
- Medical Transportation
- Outreach Services (Peer Support)
- Medical Case Management
- Mental Health

CAN Community Health (CAN)
4615 Philips Highway, Jacksonville, FL 32207
(904) 508-0710

- AIDS Pharmaceutical Assistance
- Non-medical Case Management – Eligibility
- Oral Health
- Outreach Services (Peer Support)
- Outpatient and Ambulatory Medical Care

Florida Department of Health – Duval County
515 West 6th Street, Jacksonville, FL 32206
(904) 253-1250

- Pharmaceutical Assistance
- Emergency Financial Assistance
- Oral Health

Gateway Community Services
555 Stockton Street, Jacksonville, FL 32204
(904) 387-4661

- Substance Abuse – Residential

Jacksonville Area Legal Aid
126 W Adams Street, Jacksonville, FL 32202
(904) 356-8371

- Legal Services

Lutheran Social Services
4615 Philips Highway, Jacksonville, FL 32207
(904) 448-5995

- Medical Case Management
- Mental Health
- Medical Nutrition Therapy
- Home and Community Based Health
- Outreach Services (Peer Support)
- Transitional Housing
- Health Education / Risk Reduction
- Psychosocial Services
- RW Food Pantry
- Jail Link Services

Northeast Florida AIDS Network
2715 Oak Street, Jacksonville, FL 32205
(904) 356-1612

- Medical Case Management
- Health Insurance Premium Assistance
- Outreach Services (Peer Support)
- Transportation
- Medical Nutrition Therapy
- Food Bank

University of Florida – UF Cares
655 8th Street West, Jacksonville, FL 32209
(904) 244-2120

- Outpatient and Ambulatory Medical Care
- Medical Case Management
- Nutritional Therapy

CLIENT RIGHTS, RESPONSIBILITIES AND GREIVANCE PROCEDURES

THIS IS YOUR COPY	THIS IS YOUR COPY
RIGHTS	
You have the right to receive timely, respectful, high quality services from the staff of all providers without regard to age, ethnicity, gender, disability, religion, sexual orientation, values and beliefs, and marital status.	
You have the right to request copies of all singed documents and have access to your service record.	
You have the right to participate in the development of your plan of care.	
You have the right to choose the provider and type of services and care required within the scope of clinical responsibility.	
You have the right to receive current information and education about the disease, the medicines, treatment and self-help measures.	
You have the right to appeal decisions with which you do not agree and to complete a patient grievance form.	
You have the right to request an interpreter to enhance communication.	
You have the right to refuse recommended treatment plans as allowed by law based up on the patient/client's judgment of risks and benefits and without pressure or unwanted influence from the health care provider.	
RESPONSIBILITIES	
You are responsible for conducting yourself in a courteous and respectful manner and also for responding in a timely manner to all appointments. Offensive language, verbal or physical threats, and aggressive behavior will not be tolerated.	
You are responsible for keeping all appointments.	
You are responsible for notifying the provider of services if any illness interferes with scheduled appointments.	
You are responsible for working with your Case Manager to develop a plan of care.	
You are responsible for providing all documentation needed to assist in enrolling you in any eligible programs or services.	
You are responsible for notifying your Case Manager when you have problems in obtaining services or when you are dissatisfied with your care.	
You are responsible for following the instructions of your health care provider to the best of your ability.	
You may be responsible for a portion of the costs of your health care services.	
You are responsible for notifying your Case Manager of any changes in your address, income, and living arrangements.	
GRIEVANCE PROCEDURES	
If you are dissatisfied with the services you are receiving, you may voice a complaint or grievance to your Case Manager.	
If you are not satisfied with the results of the meeting with your Case Manager, you may, within 30 days, request a hearing with the designated grievance officer of this service provider.	
If you are unable to resolve the issue with the grievance officer, you may, within 30 days, file your complaint or grievance in writing to: Ryan White Program Manager, Social Services Division, 1809 Art Museum Drive, Suite 100, Jacksonville, FL 32207.	
The Ryan White Program Manager will respond in writing within 14 days of receipt of your grievance or complaint informing you of the time and place of a hearing.	
At the hearing, you may be accompanied by a friend, relative, legal counsel or spokesperson. The decision of the hearing officer is final.	