PUBLIC HEALTH DIVISION
HIV Community Services Program

Oregon Health Authority

Intake / Annual Eligibility Review

Confidential — this form must be saved on a secure network accessible only by Ryan White funded staff.

☐ Initial intake	Date completed: / /	☐ Annual review	Date completed: / /
Social Security number: - -	Age:	DOB: / /	

Personal information

County:

Legal last name	Legal first name	Middle initial	Other names used

Pro-Noun

☐ She/Her/Her ☐ He/Him/His ☐ They/Them/Their ☐ Ze/Hir/Hirs ☐ Other:

Street address *(if homeless, complete affidavit on page 5)*	City	State	ZIP	O.K. to receive mail? Enter in CAREWare
				☐ No ☐ Yes

Mailing address, if different	City	State	ZIP	O.K. to receive mail? Enter in CAREWare
				☐ No ☐ Yes

Home phone number	O.K. to leave message?	Cell phone number	O.K. to leave message? / O.K. to send text message?
- -	☐ No ☐ Yes	- -	☐ No ☐ Yes / ☐ No ☐ Yes
Message phone number	**O.K. to leave message?**	**Message phone name and relationship:**	**Current ROI on file?***
- -	☐ No ☐ Yes		☐ No ☐ Yes
Email address	**O.K. to send email message?**	**If no contact through phone, mail or email, state plan for eligibility review:**	
	☐ No ☐ Yes		

Key contacts

Emergency contact	Relationship	Phone number	Aware of HIV status ☐ / O.K. to leave message?
		- -	☐ No ☐ Yes
Do you have a payee? ☐ No ☐ Yes **If yes, payee name:**	**Relationship**	**Phone number** - -	**ROI obtained?** ☐ No ☐ Yes
Primary care physician	**Phone number**	**Pharmacist**	**Phone number**
	- -		- -

*On ROI specify what type of information can be shared

Clinic Name:		Clinic Name:	
HIV specialist	**Phone number**	**Dentist**	**Phone number**
Clinic Name:	- -	Clinic Name:	- -

Sex assigned at birth: ☐ Male ☐ Female	**Gender identification:** ☐ Male ☐ Female ☐ Transgender (M → F) ☐ Transgender (F → M) ☐ Other:

Ethnicity and race ☐ Hispanic or Latino[1] ☐ Non-Hispanic or Latino ☐ White or Caucasian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander[3] ☐ Asian[2] ☐ American Indian or Alaska Native ☐ Other *(Specify)*:

[1] If Hispanic or Latino:
☐ Mexican, Mexican American, Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other Hispanic origin

[2] If Asian:
☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian origin

[3] If Native Hawaiian or Pacific Islander:
☐ Native Hawaiian ☐ Guamanian or Chomoro ☐ Samoan ☐ Other Pacific Islander

Primary language: (enter in CAREWare)

Let us know if you need:
☐ An interpreter. Language I speak: ☐ English ☐ Spanish ☐ Other (*specify*):
☐ A sign language interpreter
☐ Written materials translated (*what language*): ☐ English ☐ Spanish ☐ Other (*specify*):
☐ Materials in: ☐ Audio tape ☐ Large print ☐ Braille ☐ Computer disk ☐ Oral presentation

Diagnosis and Identity (*Intake only*)

	Eligibility category	**Documentation presented** *Copies of all documentation are to be filed with this form and retained by the provider agency.*	
INITIAL INTAKE ONLY	**HIV + diagnosis**— Required only at intake. Check one: HIV diagnosis date: / /	☐ Current CAREAssist client (*prior to enrollment with this agency*) ☐ Lab test *(Viral load, Western Blot, etc.) sent from lab or physician (lab cannot show viral load as "not detected")* ☐ Documentation submitted from the healthcare provider who is providing medical care ☐ Previously obtained, is in client file ☐ Documentation of 2 Rapid HIV tests used for preliminary and confirmatory HIV verification meeting the following criteria: 1 – the rapid test kits are produced by different manufacturers; and 2 – the rapid test used for confirmatory testing has an equivalent sensitivity.	
	Verification of identity — Required only at intake. Client must provide one of	☐ Driver license ☐ Tribal ID ☐ State ID Card ☐ Military ID ☐ Student ID	☐ Social Security card ☐ Citizenship/naturalization ☐ Student Visa ☐ Birth certificate

Eligibility category		Documentation presented *Copies of all documentation are to be filed with this form and retained by the provider agency.*	
	the following:	Passport	☐ Learner's permit or temporary license ☐ List other official documents[1]:

Medical insurance (*enter in CAREWare Annual Tab*)

☐ **Health exchange**	☐ **Medicare** *(mark all that apply)*	☐ **Oregon Health Plan** (OHP) - *(Medicaid)*
☐ Qualified Health Plan (QHP) **Metal level** *(check one)*: ☐ Bronze ☐ Silver ☐ Gold ☐ Platinum	☐ Part A ☐ Part B	☐ OHP number:
	☐ Part D: ☐ Advantage Plan	☐ Coordinated Care Organization (CCO)
	☐ Low income subsidy ☐ Qualified Medicare beneficiary	☐ OHP Open Card
		☐ Dual Eligible Managed Care Organization (MCO):
		☐ Citizen Alien Waived Emergent Medical (CAWEM)

☐ **Private**	☐ **Other public**	☐ **No insurance** ☐ **Referred to case manager to complete CAREAssist application**
☐ Purchased outside the exchange	☐ VA benefits number:	**Comments**:
☐ Group policy *(through employer or spouse/parent employer)*	☐ Indian Health Services	
☐ COBRA *(end date)*: / /		

For Health Exchange, Medicare, or Private insurance plans:	
Insurance carrier:	
Plan name:	
Policy ID number:	Policy group number:
Primary policy holder's name:	Prescription ID number *(if different)*:

Medical care:	☐ None ☐ Publicly-funded or Health Department ☐ Private practice ☐ Emergency room ☐ Hospital outpatient ☐ Other (*specify*):
CAREAssist:	☐ No ☐ Yes CAREAssist number: ☐ If No, date referred to case manager/care coordinator to complete CAREAssist application:
Dental insurance:	☐ No ☐ Yes Dental plan information: ☐ If No and is on CAREAssist, date referred to case manager/care coordinator to complete CA supported dental insurance plan:

1 See "Client Eligibility" in the Support Services Guide for list of documents

Household family members living with you

Names	Relationship	Spouse, or Legal Dependent?	Age	Aware of HIV status	Release of Information (ROI) needed? *(if aware of status=yes)*
		☐ No ☐ Yes		☐ No ☐ Yes	☐ No ☐ Yes
		☐ No ☐ Yes		☐ No ☐ Yes	☐ No ☐ Yes
		☐ No ☐ Yes		☐ No ☐ Yes	☐ No ☐ Yes
		☐ No ☐ Yes		☐ No ☐ Yes	☐ No ☐ Yes
		☐ No ☐ Yes		☐ No ☐ Yes	☐ No ☐ Yes
Family size *(client + spouse + legal dependents[2])*: *(enter in CAREWare)*			**Federal poverty level listed in CAREWare:**		

Verification of income

☐ **Current CAREAssist client**. If a copy of CAREAssist Eligibility Verification (CEV) form is attached, **do not** complete verification of income or "No Income Affidavit" below (*update information from CEV in CAREWare*)

☐ **Not a CAREAssist client**: complete the income table below. Required documentation must be in the client record.

[3]

Type of income *(check all that apply per Support Services Guide)*	Person(s) receiving income	Monthly gross income	Annual gross income *(multiply monthly income to get annual)*	Required documentation *(see Support Services Guide for more detail)*
☐ No source of income			$0.00	☐ Client no income: complete the "No Income Affidavit" at bottom of form
Other Household income: ☐ Spouse, or Partner living with client with a shared legal child; ☐ Legal Dependent income			$0.00	☐ See below required documentation based on type of income and list type:
☐ Work income *(wages, tips, commissions, bonuses)*:			$0.00	☐ 2 months current, **consecutive** paystubs or earnings statements for **all** jobs
☐ Self-employment income:			$0.00	☐ Most recent federal tax return, including Schedule C *(if filed)* **AND** ☐ Previous 6 months bank statements **OR** if not available: ☐ Business records for 6 months prior to enrollment/recertification.
Social Security: ☐ Retirement ☐ SSDI ☐ Survivor's benefits ☐ SSI			$0.00	☐ Annual benefit award letter
☐ Private/Employer Pension or retirement income *(not Social Security)*:			$0.00	☐ Annual benefits award letter/statement
☐ Unemployment benefits:			$0.00	☐ Compensations stubs
Employer Disability benefits:			$0.00	☐ Compensation stubs OR

[2] Unmarried partner living with client who share a biological/adopted child in household are counted in family size and income

Type of income *(check all that apply per Support Services Guide)*	Person(s) receiving income	Monthly gross income	Annual gross income *(multiply monthly income to get annual)*	Required documentation *(see Support Services Guide for more detail)*
☐ Short Term (STD) ☐ Long Term (LTD)				☐ Benefit award letter/statement
☐ Veterans benefits:			$0.00	☐ Annual benefit award letter
☐ Stocks, bonds, cash dividends, trust, investment income, royalties:			$0.00	☐ Documentation from financial institution showing income received, values, terms and conditions.
☐ Alimony ☐ Child support *(received on a periodic or predictable basis)*:			$0.00	☐ Benefit award letter/statement **OR** ☐ Official document showing amount received regularly.
☐ Rental income:			$0.00	☐ Most recent federal tax return, including Schedule E *(if filed)* **AND** ☐ Previous 3 months bank statements
☐ Other:			$0.00	☐ Document:
Total:		Monthly = $0.00	Annual $0.00 *(Enter in CW)*	

Verification of Residency

☐ **Current CAREAssist client**: if a copy of CAREAssist Eligibility Verification (CEV) form is attached, **do not** complete verification of residency below or "Homeless/Residency Affidavit" below (*update residential address from CEV in CAREWare*).

☐ **Not a CAREAssist client**: client must provide one of the **unexpired documents** below**,** which must include client's full legal name and match residential address on this form *(update address in CAREWare)***:**

- ☐ Client is homeless– complete "Homeless/Residency affidavit" at bottom of form
- ☐ Client does not have proof of residency and is not on CAREAssist – complete "Homeless/Residency affidavit" at bottom of form
- ☐ Oregon State driver license, Tribal ID or Oregon State ID
- ☐ Utility bill *(including cell phone)*
- ☐ Lease, rental, mortgage or moorage agreement/document
- ☐ Current property tax document
- ☐ Current Oregon Voter Registration card
- ☐ Letter from lease holding roommate[4]
- ☐ Copy of public assistance/benefits letter /documentation (SSI, SSDI, TANF, etc.)
- ☐ Paystubs
- ☐ Court Corrections Proof of Identity
- ☐ Homeowner's association statement
- ☐ Military/Veteran's Affairs documents
- ☐ Oregon vehicle title or registration card
- ☐ Any document issued by a financial institution that includes residence address, such as, a bank statement, loan statement, student loan statement, dividend statement, credit card bill, mortgage document, closing paperwork, a statement for a retirement account, etc.;
- ☐ Approved letter from Oregon State Hospital, homeless shelter, transitional service provider or halfway house
- ☐ Letter on company letterhead from an employer certifying that the client lives at a non-business residence address owned by the business or corporation.

[4] Must include the lease holder's name, address that matches the client's application, relationship to the client and lease holder's telephone number.

Additional comments

Staff member below is signifying all documentation has been obtained and filed in client chart and/or uploaded in CAREWare before the Intake and/or Eligibility Review is considered complete. CAREWare Annual data and service matches date below.

Staff name and credentials

/ /

Date

No income affidavit

Completed by: ☐ Client ☐ Legal guardian

☐ I declare that I and my family have no income.

I *(we)* get food, housing, and clothing in the following ways:

I understand that I must tell my HIV case manager about any changes as part of the eligibility review. If I provide false, misleading, or incomplete information, my eligibility for Ryan White–funded services may be denied.

Client or legal guardian - signature

/ /
Today's date *(day/month/year)*

Homeless or Residency affidavit

Completed by: ☐ Client ☐ Legal guardian

☐ I am currently homeless ☐ Do not have a fixed address ☐ Do not have proof of address

I am living in the city of _____

I most often stay at the following locations:

I am a resident of Oregon and all statements regarding my housing status are true. I understand that false or misleading information may result in my benefits ending with the Oregon Health Authority (OHA), HIV Care and Treatment Programs, including CAREAssist.

Client or legal guardian - signature

/ /
Today's date *(day/month/year)*