

RYAN WHITE PROGRAM & ADAP CHANGE FORM

| CLIENT INFORMATION | | | |
|---|---|--|---|
| Last Name | First Name | Date of Birth ____ / ____ / _____ | |
| <input type="checkbox"/> CHANGE IN ADDRESS OR PHONE | | | |
| Home Address | City | State | ZIP Code |
| Mailing Address (if different) | City | State | ZIP Code |
| Shipping Address (if different) | City | State | ZIP Code |
| Home Phone | May we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No | Other Phone | May we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Housing Status | | | |
| <input type="checkbox"/> Permanently housed <input type="checkbox"/> Staying with someone <input type="checkbox"/> Homeless <input type="checkbox"/> Institution <input type="checkbox"/> Other | | | |
| <input type="checkbox"/> CHANGE IN HOUSEHOLD SIZE OR INCOME | | | |
| Household Size: | Monthly Income: | Annual Income: | |
| <input type="checkbox"/> CHANGE IN HEALTH COVERAGE PAYER | | | |
| Do you have health insurance? Check all that apply. | | | |
| <input type="checkbox"/> AHCCCS | <input type="checkbox"/> Private – Employer: _____ | <input type="checkbox"/> Veterans Affairs | |
| <input type="checkbox"/> ALTCS | <input type="checkbox"/> Private – Individual: _____ | <input type="checkbox"/> Indian Health Service | |
| <input type="checkbox"/> Medicare <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> Advantage Plan <input type="checkbox"/> D <input type="checkbox"/> Full LIS | <input type="checkbox"/> FFM Plan: _____ <input type="checkbox"/> Other: _____ | <input type="checkbox"/> No Insurance | |
| <input type="checkbox"/> CHANGE IN NAME (client required to contact CE Office to provide documentation of change) | | | |
| Name currently in CW: | | New Name to be entered in CW: | |
| Must be completed by a representative of the Ryan White provider agency. | | | |
| <input type="checkbox"/> <input type="checkbox"/> Client referred to CE Office Date: _____ | | | |
| _____ Signature of Provider Representative | | _____ Date | |
| _____ Printed Name of Provider Representative | | _____ Provider Agency Name | |
| ~~~~~ | | | |
| _____ Signature of CE Specialist | | _____ Date | |
| _____ Printed Name of CE Specialist | | CE Entered Date: _____ | |