South Dakota Ryan White Part B Initial Program Application Form

(*Return to: Ryan White Part B Program, Department of Health, 615 E. 4th Street, Pierre, SD 57501*)

Name:	**Birth Date:**	**Case Number (office use)**

Physical Address:	**City:**	**State:**	**Zip Code:**

Primary Phone:	**Secondary Phone:**	**Gender:**	**Race:**	**Hispanic/Latino** ☐**Yes** ☐**No**

What is the best time to contact you?

Mailing Address:

Current Physician	**CD4:** **Date:** **Viral Load:** **Date:**

What State were you diagnosed in:	**Date of diagnosis:**

Are you under 18 years old? ☐ **Yes** ☐ **No**	**Are you a veteran?** ☐ **Yes** ☐ **No** **Do you receive VA Benefits?** ☐ **Yes** ☐ **No**

Insurance Coverage – Applicant Insurance Information ONLY

Do you currently have Dental Insurance Coverage? ☐ **YES** ☐ **NO**
***(if yes)* Name of dental coverage provider:**

Do you currently have Health Insurance Coverage? ☐ **YES** ☐ **NO**
(if yes) Provide information below:

Medicaid ☐ **Yes** ☐ **No** **Number:**	**Medicare** ☐ **Yes** ☐ **No - Medicare Part D** ☐ **Yes** ☐ **No** **Part D Company:** **Part D Number:**
Private Insurance: ☐ **Yes** ☐ **No** **Company:** **Monthly Amount paid:**	**Coverage through Employer:** ☐ **Yes** ☐ **No** **Employer Name:** **Health Plan Name:** **Is this COBRA?** ☐ **Yes** ☐ **No** ***(I am currently employed)***

Household Income; List all household members, including yourself **that you support**.

Names	**Birthdates**	**Yearly Gross Income**
Total Income:		

I hereby certify that all of the above information is true and correct to the best of my knowledge and belief. Deliberate misrepresentation will subject applicants to prosecution under applicable State and Federal Statutes. By my signature, I authorize the South Dakota Department of Health to furnish the Ryan White Part B CARE case manager(s) and/or the SD Ryan White Part C program with a copy of this application and associated documents pertinent to the Ryan White Part B CARE Program. This authorization may be cancelled in writing at any time except to the extent the Ryan White Part B CARE Program has taken action upon it. If not cancelled, this authorization will be terminate in one year or upon the following specified date: ***ENTER DATE (one year from date signed):*** **_____.**

Applicant Signature: _____ Date: _____

Guardian Signature (if client is under 18):_____

Witness Signature: _____