Agency Name: ☐ CFHC ☐RHG ☐ Other_____ **Total Amount of Request: $_____**

Date of Service: ____/____/_____ **Ryan White Cap $**_____
HOPWA Cap $_____

Ryan White Part B and HOPWA
Client Request for Emergency Funds

Does client have Medicaid? ____No _____ Yes Client URN:_____

RYAN White Part B Payment For:

☐ Assistance Medications (when all other option exhausted)—HIV/Non-HIV/OTC

☐ Rent ☐ Utility ☐ Food ☐Health Insurance Premium/Cost Sharing

HOPWA SERVICES **Payment For:** ☐ Rent ☐ Mortgage ☐ Utility

Need Statement:/Why does client not have funds (BE SPECIFIC)? _____

_____

_____

EXTERNAL RESOURCES CONTACTED – must list 3 other resources and have documentation attached

County of Residence: _____

1. ☐ Social Services: _____ **2.** ☐ Community Agency_____
(Name of person at Agency) (Name of Agency)

_____ **3.** ☐ _____ _____
(Name of person at Agency) (Name of Agency) (Name of person at Agency)

Date of last medical visit: _____Medical Provider: _____

CD4_____Date____/____/_____ Viral Load_____ Date____/____/_____ Annual Pap/Pelvic____/____/____

Housing Plan Documented? ☐ Yes ☐ No Working Smoke Detector? ☐ Yes ☐ No

Aware of lead paint poisoning? ☐ Yes ☐ No Does client live in a mobile home? ☐ Yes ☐ No

Does the mobile home have a foundation? ☐ Yes ☐ No

Check Payable to:_____

Address: _____

Notes:_____

_____

Client URN: _____

I certify that the information above is correct. I, the client, understand that I may have met my limit for the year for emergency funds that are available or in the future, funds may not be available due to budget limitation and cutbacks. Therefore, it is my responsibility to plan and budget accordingly for my future needs.

_____ _____

Client Initials and Date Case Manager Service Provider's Signature and Date

Case manager must attach: ☐ Current CD4 count and viral load (within the last 4-6 months)

☐ Pap smear (for women with cervix within the past year)

☐ Assessment and intake forms

☐ Utility/rent or other bill

☐ Documentation of income (Form 3014 AND payroll stubs, Social Security Statement, verification of No/Low income)

☐ Documentation of NC residency (if lease and/or utility bill not included)

Other: ☐ MD progress notes (within the last 4-6 months)

☐ Requests for funds from 3 other agencies

☐ Other labs (lipid panel, RPR, hepatitis screening B & C)

Number of units (15 minutes) spent in preparation of application: _____ **Resource development**

_____**Assessment for emergency funds.**

OFFICE USE ONLY:

HOPWA $ received this fiscal year, prior to today $_____. Will HOPWA funds be used help with this request? **Yes or No**

If No, please explain why.

☐ Patient not eligible, Please explain_____

☐ HOPWA cap met for fiscal year (June 1- May 31)

☐ No HOPWA funds available at this time

Number of days in which assistance is requested : _____

RYAN WHITE EFA $ RECEIVED THIS FISCAL YEAR (April 1 – March 31) $_____

Is the client eligible for emergency funds: Yes No, explain: _____

If yes, please check what funding source(s) and amount have been utilized today:

☐ Ryan White_____ ☐ HOPWA_____

If partial use of funds allocated, please indicate how much additional funds are available through this funding source in the future if funds are available _____HOPWA (STRUMU) or $ _____ RW .

Total number of days in which assistance has been granted (may not exceed 147): _____

☐ Mail Check ☐Pay by phone (utilities only) or ☐Delivered by_____

Medical Case Manager Supervisor:_____Date:_____

Client utility or rent account Number: _____

HOPWA Request only Client URN:

Household Demographics: *List information for all people living in the house including the client.*

URN for each household member	**Age**	**Gender** M=male F= female	**Income** 0-250 251-500 501-1000 1001-1500 1501-2000 +2001	**Race** B= black W = white Other = please indicate	**Ethnicity** Latino Yes or No	**Housing Status** 1=individual owns home 2=individual stays with family 3= individual rents apartment, room or house	**Veteran Status** 1= yes 2= no

Gross Monthly income $_____ # in Family Unit _____

# of Bedrooms _____

80% of county of residence median family income (use county charts): _____

Amount of annual income_____, Yes or No

PLEASE REFER TO INCOME LIMIT SPREADSHEETS. CLIENTS ARE NOT ELIGIBLE IF THEY ARE ABOVE 80% OF THE MEDIAN FAMILY INCOME LIMITS.

Client is 51% - 80% of median family income? ____

Client is 31% - 50% of median family income? ____

Client is 0% - 30% of median family income? ____

A copy of all 3 pages must be given to Administrative Assistant.