



Client Services  
1223 W. Pratt Street, Baltimore, MD 21223  
Phone: (410) 767-6535 or Toll Free: 1-800-205-6308  
or TTY- Maryland Relay Service 1-800-735-2258  
Fax Numbers: (410) 333-2608; (410) 244-8617

# Maryland AIDS Drug Assistance Program

## Client Services Enrollment Application

### GENERAL INFORMATION

MADAP ensures that people living with HIV/AIDS in Maryland have access to the medication they need to stay healthy. MADAP is a statewide program and is funded primarily through the Ryan White CARE Act. MADAP pays for medications for eligible clients with no insurance and helps clients with insurance by paying for eligible insurance premiums, copay, and deductible costs so that clients can get their medication. The list of medicines covered by MADAP (the MADAP formulary) includes all FDA-approved HIV treatment medications, a wide range of medications used to treat opportunistic infections and complications of HIV infection or related conditions.

Clients approved for MADAP must re-apply for the program annually. Clients enrolled in MADAP can use MADAP to receive their medications at any of the Maryland Medicaid network pharmacies that accept Maryland Medical Assistance (Medicaid). When you are approved, you will receive a welcome letter and a MADAP ID card. You must present your MADAP ID card with your prescription(s) at a participating pharmacy to receive covered medications at no charge.

### CLIENT SERVICES CONFIDENTIALITY STATEMENT

HIPAA Privacy Rule/Confidentiality/ Acknowledgement of MDH Privacy Policy MDH complies with the Health Insurance Portability and Accountability Act (HIPAA) privacy rule [45 CFR § 160.102]. Client-level data related to enrollment will be reported only as required by law.

Clients have the right to confidentiality of all information and records compiled, obtained, and maintained in the course of applying for and/or receiving services.

Email addresses will not be sold to any third-party vendors or used to communicate one's specific case. Email addresses will only be used to quickly relay any updates and important information pertaining to the program.

### APPLICATION INSTRUCTIONS

#### New Clients

This enrollment application must be completed, signed, and submitted for eligibility determination and include the required documentation applicable to your circumstances. Once your eligibility is approved, this will be your official enrollment application on file with Client Services.

Only complete applications will be considered for eligibility, so please provide all information requested. If a question or request is not applicable to you, answer "n/a". Include all required documents with your enrollment application. Please have your clinician complete, sign, and submit Form A-1: Medical Eligibility Form.

#### Active Clients

Client Services requires you to recertify your eligibility annually. The annual eligibility recertification occurs by the end of the 12th month of your enrollment period. The annual eligibility recertification form is due by the end of the 11th month of your eligibility period. It will be sent to you prior to the end of the 11th month of your eligibility period.

- You must renew eligibility by submitting a completed and signed annual recertification form along with the required supporting documentation for residency and income.

### **Inactive Clients/Re-Enrolling**

- If you previously were assigned a client ID, but your services are not currently active, you can re-enroll by following the guidance below:
  - If it has been 2 or more years since you were active, please complete and submit the Full Client Services Enrollment Application.
  - If it has been less than 2 years since you were active, please complete and submit the Annual Client Services Recertification Form.

## **I: APPLICANT INFORMATION & II: MARYLAND RESIDENCY**

### **Name**

List your full name, social security number, and date of birth.

### **Address**

Residency documentation must include the client's name and current address. Documentation must be current (e.g., current lease, recent utility bill, etc.). Acceptable proof of residency may include, but is not limited to, the following:

- Current notice of decision from Medicaid
- Valid Maryland driver's license or Maryland Identification card dated within the last 12 months
- Voter registration card dated within the last 12 months
- Current signed and dated lease (within the last 12 months) or current mortgage agreement
- Rent receipt, dated within the last 60 days
- Current utility bill, dated within the last 60 days
- Letter from a government agency, signed and dated within the last 60 days and mailed to the client's home; a letter from a case manager on agency letterhead, signed and dated within the last 60 days and mailed to the client's home

Unhoused applicants may provide a letter stating they are without a home. The letter must be written on agency letterhead and be signed and dated within the last 60 days. MADAP's A-2 Verification of No Income Form may be submitted in place of a letter.

The following individuals may verify that the client is without a home:

- Case manager
- Housing manager
- Any staff member employed by an agency who receives Ryan White support

### **Sex/Race/Ethnicity/Language**

Please check your sex, race, ethnicity, and language preference.

## **III: MEDICAL ELIGIBILITY CRITERIA**

Medical Eligibility Criteria can be met by providing documentation using **one** of the options below:

- Lab reports that show diagnosis or viral load
- The A-1 Medical Form: The Medical Eligibility Form must be completed, dated, and signed by your licensed medical practitioner who provides your medical care. The practitioner must answer all questions to support your eligibility. This form can either be included in your enrollment application or sent directly to client services from your practitioner's office. This form is only required once; if you are unsure we have a medical form on file, please contact Client Services.

#### **IV: HOUSEHOLD/PROJECTED GROSS INCOME**

Household includes the applicant, spouse, and all dependents on your federal tax return. If you do not file taxes, list the people in your household whom you support financially.

#### **V: HEALTH & PRESCRIPTION PLAN COVERAGE INFORMATION**

You must submit a copy of the front and back of all your insurance card(s) with this application so that we can verify your benefits. Also, submit a copy of any enrollment letter(s) you have received for LIS/Extra Help, SPDAP, or QMB/SLMB, if applicable.

#### **VI: CLIENT SERVICES PLUS (*Insurance Premium Payment Assistance*)**

Client services can assist with insurance premiums during approved eligibility periods. If you would like to request insurance premium payment assistance upon client services eligibility determination, please submit your health/prescription payment documentation (see chart on page 10) with this application. You will be contacted about Client Services Plus enrollment determination after your eligibility has been approved and your insurance coverage has been verified.

##### **Covered plan types:**

- QHP from the Maryland Health Benefits Exchange (on-exchange)
- QHP directly from the insurance carrier or through an insurance broker (off-exchange)
- Medicare Part C Plan
- Medicare Part D - Prescription Drug/Advantage Plan
- Medicare Supplemental Plans (Medigap), only if the client has an active Part D plan or creditable coverage
- Dental and Vision Policies are only if Client Services is paying for the client's health and/or prescription coverage.
- Private Employer-based plans (applicant's or spouse's employer, union, or retirement plan): if the client pays 50% or more of the premium, the plan covers your medication, and the employer will accept payment from the State of Maryland insurance program.

##### **Plans not covered:**

- Medicare Part A – Hospital Coverage
- Medicare Part B – Medical Coverage or Creditable Coverage (a plan usually obtained through an employer)
- VA/Tricare; I.H.S. (Indian Health Services);
- Maryland Medicaid (Medical Assistance) or Maryland Children's Health Program
- Private medical or prescription plans that do not cover HIV drugs or provide HIV care and employer plans where the employer does not accept payment from the program.



Client Services Enrollment Application

Client Services ID (if applicable):
Are you a new applicant to Client Services? Yes No

- Applying for (check one):
Drug Assistance
Drug and Insurance Premium Payment Assistance

If you have prescription coverage through Maryland Medicaid, you are NOT eligible.

Section I: Applicant Information: Items with an asterisk mark (\*) must be filled in for this form to be considered completed. Incomplete forms will delay the processing of your application.

\*First Name: Middle Initial: \*Last Name: Suffix:

\*Date of Birth (MM/DD/YYYY): \*Social Security Number:
Check if you do not have a social security number. ITIN (if applicable):

\*Residential Address (proof of residency is required; see Section 2):

\*Street: Apt#:

\*City: \*State: \*Zip Code:
I am without a home and live in Maryland. (check if applicable, complete and submit Form A-2)

Mailing Address (if different from residential address):

Street: Unit/Apt#:

City: State: Zip Code:

\*Telephone numbers where Client Services staff can reach you:

Home: ( ) - - May we leave a detailed message? Yes No

Work: ( ) - - May we leave a detailed message? Yes No

Cell: ( ) - - May we leave a detailed message? Yes No

Email address where Client Services staff can reach you:

(see page 1, Client Services Confidentiality Statement, for more information.)

Case Manager:

Name:

Provider Site: Phone number:

Primary HIV Physician:

Name:

Provider Site: Phone number:

- Gender at Birth:**  Male  Female
- \*Gender:**  Male  Female  Transgender (  Male to Female  Female to Male)
- \*Legal Marital Status:**  Single  Married  Divorced  Widowed  Separated
- Sexual Orientation:**  Straight or Heterosexual  Lesbian, Gay, or Homosexual  Bisexual  
 Don't know  
 Something else (please specify): \_\_\_\_\_  
 Choose not to disclose

- \*Race** (Check all that apply):
- Black or African American**  **White**  **American Indian/Alaskan Native**
  - Native Hawaiian/Pacific Islander** (Check all that apply):
    - Native Hawaiian**  **Guamanian or Chamorro**  **Samoa**  **Other Pacific Islander**
  - Asian** (Check all that apply):
    - Asian Indian**  **Vietnamese**  **Korean**  **Japanese**  **Chinese**  **Filipino**  **Other Asian**
  - None of these apply**

- \*Ethnicity:**
- Non-Hispanic**
  - Hispanic/Latino(a)** (Check all that apply):
    - Mexican, Mexican American, or Chicano/a**  **Puerto Rican**  **Cuban**
    - Another Hispanic, Latino(a), or Spanish origin**
  - None of these apply**

- \*Citizenship/ Immigration Status:**
- U.S. Citizen**
  - Not a citizen or permanent resident of the U.S.**
  - Green Card** (attach a copy of the card)
  - Asylee** (attach documentation)

**\*Section II: Maryland Residency:** Documentation must include your name and residential address as displayed in Section I. Check the type of legible documentation being attached to verify your Maryland residency (choose one):

**Documents that must be dated within the past 60 days of submitting this application:**

- Bills - (examples: utility, health insurance premium, cell phone, cable service, car or hospital)
- Employment:
  - Paystubs (one month)
  - Unemployment: Determination letter
  - Other: A-2: Verification of No Income/Unhoused Verification Form
  - A-3: Cash Only Verification Form
- Change of address card from a U.S. Post Office or MVA (Maryland Vehicle Admin.)
- Bank statement
- Windowless envelope with dated postmark addressed to you, received at your residential address previously identified

**Documents that must be dated within the past year of submitting this application:**

- Social Security Award Letter
- Lease or Mortgage
- Driver's License

## Section III: Medical Eligibility Criteria:

### Are you a new applicant to Client Services?

- Yes, I have never been enrolled in the program.  
 No, I am currently enrolled or have been enrolled in the past. **This section is not applicable to you.**

The **A-1: Medical Eligibility Form** must be completed, dated, and signed by your licensed medical practitioner who provides your medical care. The practitioner must answer all questions to support your eligibility. This form can either be included in your enrollment application or sent directly to client services from your practitioner's office. This form is only required once; if you are unsure we have a medical form on file, please contact Client Services. **Lab reports that show diagnosis or viral load can be used in place of the A-1 Medical Eligibility Form.**

**\*Section IV: Household/Projected Gross Income:** *Household includes the applicant, spouse, and all dependents on your federal tax return. If you do not file taxes, list the people in your household whom you support financially.*

**Is the applicant under the age of 19 and financially supported by parent(s)/guardian(s)?**  Yes  No (If yes, please complete **A**; if no, proceed to **B**)

### **A. Parental Information**

#### **Parent/Guardian 1:**

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_ Suffix: \_\_\_\_\_

Date of Birth (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
 Check if there is no social security number.  
ITIN (if applicable): \_\_\_\_\_

#### **Parent/Guardian 2:**

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_ Suffix: \_\_\_\_\_

Date of Birth (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
 Check if there is no social security number.  
ITIN (if applicable): \_\_\_\_\_

### **B. Marital Information** (if applicable):

#### **Spouse:**

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_ Suffix: \_\_\_\_\_

Date of Birth (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
 Check if there is no social security number.  
ITIN (if applicable): \_\_\_\_\_

**C. Natural, Adopted, Stepchildren/Siblings** (attach additional sheets if necessary):

Do you have any children/siblings who live within the household who are under the age of 19?  Yes  No.

(If yes, please list each child's name, age, and date of birth.)

Name	Date of Birth	Age
Child 1: _____		
Child 2: _____		
Child 3: _____		
Child 4: _____		

**Additional Members of your household** (not listed above):

Name	Relationship	Do you plan to claim this person as a dependent on your taxes?	If yes, please provide their social security number
		<input type="checkbox"/> Yes <input type="checkbox"/> No	SS# _____
		<input type="checkbox"/> Yes <input type="checkbox"/> No	SS# _____
		<input type="checkbox"/> Yes <input type="checkbox"/> No	SS# _____

**D. Household Income:** \*You are required to report all your household's gross income, including your income, your legal spouse's income, and the income of any dependents, even if it is zero (\$0). Provide the requested information:

1. Recipient	Income Source(s)	How Often	Gross Amount
<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Household member		<input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Seasonal: # of Months paid: _____	(before deductions) \$ _____
<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Household member		<input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Seasonal: # of Months paid: _____	(before deductions) \$ _____
<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Household member		<input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Seasonal: # of Months paid: _____	(before deductions) \$ _____
<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Household member		<input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Seasonal: # of Months paid: _____	(before deductions) \$ _____

\*Total number of household members: \_\_\_\_\_

\*Total household annual gross income: \$ \_\_\_\_\_

Based on the reported household income in the previous section, please submit a copy of the required supporting documentation for each source of income as described in the following chart.

Income Source	Supporting Documentation
Wages and Salaries (including tips)	One month's gross pay stubs (including tips) dated within the last 60 days
Net Income from Self-Employment	Most recent submitted quarterly tax statements or Receipts, Journal, Manifests for the most recent 30 days, or Business Checking and/or Savings Bank Statements for the most recent 60 days)
Alimony, Retirement, Pension, Annuity, Investment Dividends or Interest	Statement of monthly payments.
Current Unemployment Benefits	Current Unemployment letter/printout with balance
Social Security	Current award letter from Social Security Administration, inclusive of disability, if applicable.
Rental Property	Statement of net income.
Other Taxable Income (prizes, awards, gambling winnings)	Statement and evidence of other taxable income.
No Income, supported by others	A-2: No Income and/or without a home Verification Form -completed by the person who supports you.
Cash only Income	A-3: Cash Only Verification Form

**Do not report the following types of income:** child support; gifts, Supplemental Social Security Income; Veterans' disability payments; workers' compensation, or proceeds from loans, such as student loans, home equity loans, bank loans, school stipends such as scholarships or fellowship payments for tuition, fees, and course-related expenses that are necessary for all students.



## Section V: Health & Prescription Plan Coverage Information:

You must submit a copy of the front and back of all your insurance card(s) with this application, so we can verify your benefits. Also, submit a copy of any enrollment letter(s) you have received for LIS/Extra Help, SPDAP, or QMB/SLMB, if applicable.

### Complete the following for Health and Prescription Insurance plans

#### Pharmacy Benefits:

Complete the section below if you have pharmacy benefits or submit a copy of the front and back of your pharmacy benefits card.

Company Name: \_\_\_\_\_

Rx BIN: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_

Rx PCN: \_\_\_\_\_

Effective Date: \_\_\_\_\_

Rx Group: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Plan ID: \_\_\_\_\_

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#### Health Insurance Plans:

##### Primary Health Coverage (Choose plan type):

Individual    Individual/Spouse

Family    Individual/Child

Insurance company name: \_\_\_\_\_

Policy holder name: \_\_\_\_\_

Phone number: \_\_\_\_\_ Plan number: \_\_\_\_\_

Member ID: \_\_\_\_\_ Group ID: \_\_\_\_\_

Effective date: \_\_\_\_\_

##### Secondary Health Coverage (Choose plan type):

Individual    Individual/Spouse

Family    Individual/Child

Insurance company name: \_\_\_\_\_

Policy holder name: \_\_\_\_\_

Phone number: \_\_\_\_\_ Plan number: \_\_\_\_\_

Member ID: \_\_\_\_\_ Group ID: \_\_\_\_\_

Effective date: \_\_\_\_\_

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#### Complete the following for all Other Plans:

Type of Coverage: \_\_\_\_\_

Type of Coverage: \_\_\_\_\_

Company Name: \_\_\_\_\_

Company Name: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_

Plan ID#: \_\_\_\_\_

Plan ID#: \_\_\_\_\_

Effective Date: \_\_\_\_\_

Effective Date: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_

#### If you do NOT have health insurance, check all the reasons why below:

Cost of premiums    Cost of co-pays    Not interested    Other (describe): \_\_\_\_\_

Check here if you need help obtaining insurance

**Section VI: Client Services Plus:** *Insurance Premium payment assistance Client Services will only provide premium assistance during approved eligibility dates.*

Client services can assist with insurance premiums during approved eligibility periods. If you would like to request insurance premium payment assistance upon determination of client services eligibility, please submit your health/prescription payment documentation (see chart below) with this application. You will be contacted about Client Services Plus enrollment determination after your eligibility has been approved and your insurance coverage has been verified.

Type of Plans Covered	Payment Documentation Needed
QHP from the Maryland Health Benefits Exchange (on-exchange)	Monthly Premium Invoice/Bill
QHP directly from the insurance carrier or through an insurance broker (off-exchange)	Monthly Premium Invoice/Bill
Medicare Part C Plan	Invoice or Coupon Booklet
Medicare Part D - Prescription Drug/Advantage Plan	Invoice/Bill or Coupon Booklet
Medicare Supplemental Plans (Medigap), if the client has an active Part D plan or creditable coverage	Invoice/Bill or Coupon Booklet
Dental and Vision Policies: If Client Services is paying for the client's health and prescription coverage,	Invoice/Bill or Coupon Booklet
Private Employer-based plans (applicant's or spouse's employer, union, or retirement plan): if the client pays 50% or more of the premium, the plan covers your medication, and the employer will accept payment from the State of Maryland insurance program.	<p>Provide a letter from your employer that includes the cost of your monthly premium, the percentage the employer pays, the percentage you pay, where to send payment with who to address the check to, and whether your employer will accept a payment from a State of Maryland insurance program.</p> <p>Client services staff must be able to arrange payment of the applicant's portion of the premium. Staff will need to communicate with the employer to make arrangements for a payment plan approved by the employer.</p>
<b>Plans not covered:</b>	
Medicare Part A – Hospital Coverage	
Medicare Part B – Medical Coverage or Creditable Coverage (a plan usually obtained through an employer)	
VA/Tricare; I.H.S. (Indian Health Services); Maryland Medicaid (Medical Assistance); or Maryland Children's Health Program	
Private medical or prescription plans that do not cover HIV drugs or provide HIV care and employer plans where the employer does not accept payment from the program.	

**It is your responsibility to provide monthly premium statements to Client Services for timely payments.**

## Section VII: Release & Exchange of Information:

I certify that the information provided in this application is complete and accurate to the best of my knowledge.

- I understand that, for the purposes of determining my eligibility for services, the Maryland Department of Health (MDH) may request further documentation.
- I authorize my physician, case manager/social worker, and health care providers to exchange information with the MDH that documents my diagnosis and need for services from MDH.
- I authorize MDH to exchange information with my physician, case manager/social worker, health care providers, insurance carrier(s), and/or pharmacy provider(s) to facilitate the provision of Client Services as needed.
- I understand that if MDH requests it, I am required to attest to continuing eligibility and provide supporting documentation within the specified timeframe given. I understand that my non-compliance with verifying my continued eligibility will result in suspension or termination of my services.
- I agree to notify MDH (*at the address on this form*) of any circumstances affecting my eligibility for services. I agree to notify MDH within 10 days of my address, income, or other information changes. (COMAR 10.18.05.04A)
- I authorize MDH to contact me via phone, email, or mail to exchange information related to my case. If a phone call is made, I will let MDH know if they are approved to leave a voice message and/or speak with an alternate contact on my behalf.

### Consumer's rights:

- If my application is denied, I have the right to request a reconsideration (COMAR 10.18.05.05A), and if I am dissatisfied with the reconsideration (COMAR 10.18.05.05C), I may request an appeal hearing.
- I understand that I may revoke this authorization at any time in writing. However, this release shall remain valid until I inform Client Services, in writing, of my wish to terminate services or until such time as I no longer qualify for these services, whichever occurs first, except to the extent that action has been taken in reliance on this authorization.

**\* Alternate Contacts:**

I authorize Client Services to speak with the following person(s) about my application and/or services (e.g., family member):

Name	Relationship	Phone number	Email
_____	_____	_____	_____
_____	_____	_____	_____

I certify that the information I have given on this application is true, correct, and complete. I agree to provide documentation upon request as required by MDH. I acknowledge receipt of MDH Privacy Practices and Consumer Rights policies and agree to the Release and Exchange of Information.

**\*Applicant Name:** \_\_\_\_\_  
(please print)

**\*Signature of Applicant:** \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(or legal guardian if the applicant is a minor)

**\*Spouse Signature:** \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(if applicable)

**\*Application Quick Check List\* Please initial next to each line to confirm you have submitted all necessary documentation to process your application in a timely manner.**

- \_\_\_\_ **Proof of residency,**
- \_\_\_\_ **Proof of Income, and/or**
- \_\_\_\_ **Medical/labs documents are attached (if applicable)**
- \_\_\_\_ **You and your spouse (if applicable) have signed the application.**
- \_\_\_\_ **If you have a Green Card or Work Permit or are an Asylee, please attach a copy**

Mail, email, or fax the completed application and supporting documentation to:

**MDH Unit #72, Client Services**  
1223 W. Pratt Street, Baltimore, MD 21223  
Fax: (410) 333-2608; (410) 244-8617  
Client.services@maryland.gov

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## Appendix

### Appendix A:

#### Acceptable Residency Documentation

- Please provide one form of acceptable proof of residency from the list below. Documentation must be current (e.g., current lease, recent utility bill, etc.). Acceptable proof of residency may include, but is not limited to, the following:
  - Current notice of decision from Medicaid
  - Valid Maryland driver's license or Maryland Identification Card dated within the last 12 months
  - Voter registration card dated within the last 12 months
  - Current signed and dated lease (within 12 months) or mortgage agreement
  - Rent receipt, dated within the last 60 days
  - Current utility bill, dated within the last 60 days
  - Letter from a government agency, signed and dated within the last 60 days and mailed to the client's home
  - Letter from a case manager on agency letterhead, signed and dated within the last 60 days and mailed to the client's home
- Unhoused applicants may provide a letter stating they do not have a home. The letter must be written on agency letterhead and be signed and dated within the last 60 days. A-2 Verification of No Income Form may be submitted. The following individuals may verify that the client is unhoused with the A-2 form or letter:
  - Case manager
  - Housing manager
  - Any staff member employed by an agency who receives Ryan White support
  - Supporting relative or friend

### Appendix B:

#### Acceptable Income Documentation

- Income includes any income earned through employment, disability, public benefits, etc. Forms of income include, but are not limited to, the following:
    - Employment income
    - Retirement income
    - Unemployment benefits
    - Supplemental Security Income (SSI)
    - Social Security Disability Insurance (SSDI)
    - Income for dependents
    - Alimony payments
    - Private disability
    - Rental property income
    - Interest income or other investment income
    - Cash support from family and friends
  - Income information should be collected for the client and individuals over the age of 18 who share financial responsibility. All income must be current, signed, and dated (e.g., current year award letter, recent pay stubs, etc.). Acceptable proof of income may include, but is not limited to, the following:
    - One month of consecutive pay stubs
    - Tax forms (W-2 form or 1099)
    - Letter on letterhead from employer stating hourly wage and hours worked per week
    - Pension benefits letter
    - Retirement benefits check or letter
    - Unemployment income check or letter
    - Disability benefits check or letter
    - Social Security check or award letter
    - Bank direct deposit indicating payment from Social Security
    - Alimony Agreement Letter
    - If receiving support from family and friends, a signed statement documenting who provides monetary support and the frequency of the support
    - If there is no income, the A-2 Verification of No Income form may be submitted
-