



Ryan White Primary Care Program

County of San Diego | Health and Human Services Agency

The Ryan White Primary Care (RWPC) Program does not cover all medical care. Neither hospitalization nor emergency room services are covered. If you are referred to Medi-Cal, you MUST apply within 60 days of this application date or you will lose your RWPC benefits. **Patients found to have other coverage are required to repay the cost of RWPC services.**

Last Name		First Name		MI	Social Security #	Mother's Maiden Name
Date of Birth	Age	Gender: <input type="checkbox"/> Transgender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> MTF <input type="checkbox"/> FTM		Housing Status <input type="checkbox"/> Rent <input type="checkbox"/> Own <input type="checkbox"/> Rent room <input type="checkbox"/> Live with family/ friends <input type="checkbox"/> Substance Abuse Treatment Facility <input type="checkbox"/> Assisted Living Facility <input type="checkbox"/> Homeless		
Hispanic? <input type="checkbox"/> Yes <input type="checkbox"/> No		Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Native Alaskan <input type="checkbox"/> Pacific Islander Other: _____				
Home Address					City	
ZIP	County	Telephone # <small>Include Area Code</small>	Monthly gross income <small>(from ADAP Application)</small>	Household Size		

- 1) Do you have health insurance, Medi-Cal, or Medicare?** Yes No
If "Yes" STOP HERE. You are not eligible for Ryan White Primary Care medical services. If "No", continue to the next question.
- 2) Do you have health insurance purchased through Covered California?** Yes No
If "Yes" STOP HERE. You are not eligible for Ryan White Primary Care Medical Services. If "No", you will be asked to sign an acknowledgement form stating that you have received information on Covered California enrollment, documentation requirements, or the possibility of incurring a fine if you decline enrollment.
- 3) Are you eligible for primary care medical services through the VA or other military facility?** Yes No
If "Yes", STOP HERE and seek medical care through your assigned military medical provider. If "No", continue to the next question.
- 4) Do you live in San Diego County?** Yes No
If "Yes", continue to the next question. If "No", STOP HERE and seek medical care in your county of residence.
- 5) Are you a US citizen or a Legal Permanent Resident (LPR)?** Yes No
Note: Your answer to this question does not affect your eligibility to Ryan White Primary Care Medical Services.
- 6) Are you between 18 and 64 years of age?** Yes No
If No, STOP HERE. If you are age 64 or younger, apply for Medi- Cal. If you are age 65 or over, apply for Medicare.
- 7) Is your household's gross monthly income less than 138% of Federal Poverty Level (FPL)?** Yes No
Note: You may ask your clinic for current FPLs.
If "Yes", you must apply for Medi-Cal within 60 days; sign and date below and give to clinic staff. If "No" and you do not have documentation, provide it within 30 days or you will no longer be eligible for RWPC. If "No" and you presented documentation of your income to show you are eligible for RWPC, sign and date below and give to clinic staff.

The above statements are true to the best of my knowledge. I authorize the release of information from my medical records to the County of San Diego and the Ryan White Primary Care Program administrative contractor. I understand that the information I have provided is subject to verification and that concealing or deliberately providing false information will result in loss of eligibility for Ryan White CARE Act services. I have received a copy of *Ryan White Primary Care Program Information for Patients* and understand which services are and are not covered. I agree to apply for Medi-Cal if referred and understand that I may be dropped from the Ryan White Primary Care Program if I do not apply for Medi-Cal within 60 days of the date signed.

Applicant Signature: _____ **Date:** _____

The patient's medical record supports RWPC eligibility; income documentation is attached. If patient received a referral/acknowledgment form check the following applicable box and attach a copy: Medicare Medi-Cal Covered California Acknowledgment form

Clinic Staff Name: _____ Clinic: _____ Phone: _____

Providers: Direct questions about this application to the HIV, STD, and Hepatitis Branch at (619)293-4716.

Distribution: white to UnitedHealthcare with a **confidential** coversheet; yellow to patient; pink to patient file

RW-1E (Feb2020)