Client Eligibility Documentation Checklist (Summary)
for Miami-Dade County Ryan White Program Services
(USE THIS VERSION BEGINNING JUNE 1, 2023 –
PAGES 1 THROUGH 5 BELOW ARE REQUIRED)

This Checklist must accompany the Out of Network Referral (OON) form, Client Self-Referrals, or the "General Revenue (GR) Short-Term Medication* Assistance through the JMH Specialty Pharmacy" form. When using this Checklist for referral purposes, please place a check mark next to the corresponding item in the lists below and attach the required documentation to the appropriate referral transmittal form. This Checklist must also be used as a standard for enrollment and recertification for client access to Miami-Dade County Ryan White Program services.

(*NOTE: the "GR Short-Term Medication Assistance" provides emergency access to antiretroviral (ARV), opportunistic infection (OI), or other medications as listed on the most current General Revenue Prescription Drug Formulary only. DO NOT REFER CLIENTS TO THE AIDS DRUG ASSISTANCE PROGRAM (ADAP) FOR SHORT-TERM (E.G., 1 MONTH) MEDICATION ACCESS.) www.miamidade.gov/grants/ryan-white-program ***– See section XII, General Revenue (GR) Short-Term Medication Assistance]***

See #4, page 5, of this checklist for what lab tests are required and when.

Acceptable forms of client eligibility documentation are listed below. At least ONE (1) document from EACH group (medical, financial, residency) below MUST be collected at enrollment or recertification, unless otherwise noted; and MUST accompany each GR or OON referral to support Ryan White Part A/MAI Program eligibility:

1) MEDICAL ELIGIBILITY: *(Proof of HIV+ status must include one of the following documents, only once)*

- □ HIV Antibody or combination antigen/antibody test followed by a subsequent test
  - Immunofluorescence Assay
  - Western Blot (WB); or ELISA (EIA) with Western Blot (WB)
  - HIV-1/2 Ag/Ab differentiating immunoassay
- □ HIV-1 p24 antigen test
- □ HIV isolation (viral culture)
- □ HIV nucleotide sequence (genotype)
- □ Lab result with detectable viral load (HIV-1 RNA):
  - Qualitative HIV Nucleic Acid Test (NAT) (DNA or RNA)
  - Quantitative HIV Nucleic Acid Test (NAT) (viral load)

2) FINANCIAL ELIGIBILITY: *[Gross household income, from earned and unearned sources, shall not to exceed 400% of the Federal Poverty Level (FPL)]*

- **NOTE:** Documents should be dated no more than 90 calendars days (3 months) prior to the program eligibility determination date, unless otherwise noted in this section.

If Employed, earned income documentation:

□ Paycheck stubs (pay stubs) for the client and their household members **for the most current two (2) months**

□ If no paycheck stubs (pay stubs) are available, a signed and dated employer statement on company letterhead (must state name of client, rate and frequency of pay, a phone number, and whether the client is currently receiving or is eligible to receive health benefits from the employer).

2) FINANCIAL ELIGIBILITY: (continued)

If Self-employed, earned income documentation:

- □ IRS 1040 Form for the most recent year with corresponding attachments (Schedule C or Schedule SE)
  - ➢ See "NOTE" under "Other earned income documentation: Tax documents…" below.
- □ Most recent IRS W-4 Forms
- □ Company accounting books showing business revenue and expenses
- □ Self-Employment Tracking Sheet (note: extenuating circumstances may call for supervisory approval)

Other earned income documentation:

Tax documents for the current or previous tax year:

- ➢ *(NOTE: within 90 calendar days of enrollment or recertification determination date)*
  - □ IRS 1040 Form
  - □ IRS 1040 Schedule C or IRS 1099-MSC Forms
  - □ IRS W-2 Form
  - □ IRS 5329 Form

- ➢ ***Unearned Income** = all income that is not acquired through current work or business activities, such as Social Security benefits, pensions, disability payments, unemployment benefits, interest income, rental property income, and cash contributions or assistance from relatives.*

Unearned Income Documentation:

- □ Letter/Notice of Award (benefit/award letters, statement, checks, or printout)
  - o HOPWA or Section 8 Rental Assistance Statement
  - o Old Age and Survivors Insurance (OASI)
  - o Social Security income / Social Security Administration (SSA)
  - o Social Security Benefit Verification Letter [formerly the Third Party Query Procedure (TPQY) screening]
  - o Social Security Disability Insurance (SSDI)
  - o Supplemental Nutrition Assistance Program (SNAP)
  - o Supplemental Security Income (SSI)
  - o Temporary Assistance for Needy Families (TANF)
  - o Unemployment benefits/compensation
  - o Veterans Affairs (VA) compensation
- □ Military/veteran pension benefits
- □ Other retirement income; retirement pension benefits statement from private or public fund (for the current or previous tax year)
- □ Child support payments or court order check
- □ Alimony payments
- □ Claim of support:
  - o Head of Household (HOH) letter detailing the client's relationship to the HOH and the level of financial assistance provided to the client;
  - o Statement of cash assistance by relatives and other individuals (included in a letter of support) when a Head of Household letter cannot be provided;
  - o NOTE: The HOH letter and statement of cash assistance cannot be completed by a spouse or someone who claims the client as a dependent on a tax return. In such cases, the tax return(s) of the household should be used.

2) FINANCIAL ELIGIBILITY: (continued)

- □ Florida Department of Revenue Suntax printout
- □ Income from rental real estate (property)
  - *IRS 1040 Supplemental Income and Loss (Schedule E) for rental property income (net income is counted in this circumstance)*
- □ Interest on investments
- □ Trust fund income or court document reflecting royalties
- □ Corrections health services referral:
  - *For example, the "Correction Health Services Referral" form from the Miami-Dade County Jackson Health System's Jail Linkage Program (JHS/JLP); must be signed and dated by the client and the referring party (e.g., JHS/JLP). This form is acceptable for the first six (6) months after enrollment in Part A/MAI, only once the client is released from jail.*
- □ Statement of No Income:
  - *For example:*
    - *the "Statement of No Income and Local Residence Form (for clients up to 25 years of age, where applicable)" – (a Miami-Dade County form)*
    - *A zero income letter from a shelter or residential treatment facility located within the county of service*
- □ Ryan White Program In Network Referral (generated through the Provide® Enterprise Miami data management system)
- □ Ryan White Program Out of Network (OON) Referral with supporting documentation
- □ Other, not listed above (requires MCM Supervisor sign-off and Miami-Dade County OMB prior approval)

3) RESIDENCY ELIGIBILITY: *(physical residential address in Miami-Dade County)*

- For purposes of Ryan White Program eligibility, proof of residency refers to an applicant or existing client currently living within the geographic boundaries of the county in which services will be provided or received. A specific number of weeks or months are not required to be considered as being a resident living in Miami-Dade County; **however**, an applicant or existing client's intent to remain in Miami-Dade County long-term and ongoing is of interest, particularly for medical care and treatment services. Applicants and existing clients may have unusual circumstances, such as the unpredictability of migrant work, that require consideration of or approval from the program Recipient, Miami-Dade County Office of Management and Budget. **(NOTE: Ending the HIV Epidemic services do not have a county residency requirement.)**

- **Documents must be in the client's name and dated no more than 90 calendar days (3 months) from the eligibility determination or verification date, except where noted below.**

  - □ Current and valid (i.e., not expired) government-issued State of Florida **driver's license** with a Miami-Dade County address
  - □ Current and valid (i.e., not expired) government-issued State of Florida **identification card** with a Miami-Dade County address
  - □ Housing, rental, or mortgage agreement **(NOTE: Handwritten rent receipts are no longer acceptable as Proof of Residency.)**
  - □ Most recently filed property tax receipt
  - □ Most recently filed IRS W-2 Form
  - □ Resident Verification Statement (e.g., zero income and/or residency letter) completed by one of the following:
    - Case manager or Medical Case Manager
    - Shelter or residential substance abuse treatment facility, if located in Miami-Dade County

3) RESIDENCY ELIGIBILITY: (continued)

- ☐ Claim of Support
  - Includes Head of Household (HOH) letter only if the client physically resides with the person completing the HOH letter
- ☐ Letter/Notice of Award (benefit/award letters, statement, checks, or printout)
  - HOPWA or Section 8 Rental Assistance Statement
  - Old Age and Survivors Insurance (OASI)
  - Social Security income / Social Security Administration (SSA)
  - Social Security Benefit Verification Letter [formerly the Third Party Query Procedure (TPQY) screening]
  - Social Security Disability Insurance (SSDI)
  - Supplemental Nutrition Assistance Program (SNAP)
  - Supplemental Security Income (SSI)
  - Temporary Assistance for Needy Families (TANF)
  - Unemployment benefits/compensation
  - Veterans Affairs (VA) compensation
- ☐ Declaration of Domicile
- ☐ Florida Medicaid Management Information System (FLMMIS) printout; or verification (i.e., Medicaid Verification)
- ☐ Self-Declaration of Homelessness
- ☐ Official correspondence postmarked to a physical residential address
- ☐ Utility bill
- ☐ Statement from a financial institution
- ☐ Voter Registration Card
- ☐ Department of Corrections Certification or Recent Prison release records
- ☐ Corrections offender website search with photo (printout)
- ☐ Corrections health services referral:
  - For example, the "Correction Health Services Referral" form from the Miami-Dade County Jackson Health System's Jail Linkage Program (JHS/JLP)
  - Must be signed and dated by the client and the referring party (e.g., JHS/JLP)
  - This form is acceptable for the first six (6) months after enrollment in Part A/MAI, only once the client is released from jail.
- ☐ School records
- ☐ Property search of Miami-Dade County Tax Collector website (https://miamidade.county-taxes.com/public) if the dwelling is the client's primary residence
- ☐ Statement of No Income:
  - *For example:*
    - *the "Statement of No Income and Local Residence Form (for clients up to 25 years of age, where applicable)" – (a Miami-Dade County form)*
    - *A zero income letter from a shelter or residential treatment facility located within the county of service*
- ☐ Ryan White Program In Network Referral (generated through the Provide® Enterprise Miami data management system)
- ☐ Ryan White Program Out of Network (OON) Referral with supporting documentation
- ☐ Other, not listed above (requires MCM Supervisor sign-off and Miami-Dade County OMB prior approval)

4) ADDITIONAL: LAB TEST RESULTS *[check appropriate box(es) below]*:

- *[**NOTE:** CD4 and HIV viral load (VL) test results are **not required at enrollment or recertification** for Ryan White Program services or to use the GR Short-term Medication Assistance Process. **However,** CD4 and VL test results **are needed by Parts A, B, and ADAP to monitor client adherence** to treatment and client health outcomes. These tests **should be ordered regularly, at least once per year, including** during the first Test & Treat / Rapid Access (**TTRA**) medical visit, **and the results shall be provided to** the respective programs.]*

☐ **At Initial enrollment for Ryan White Program or GR Short-term Medication Assistance (CD 4 and VL, NOT required)**

☐ **At Recertification (CD 4 and VL, NOT required)**

☐ **Out of Network (OON) Referral: a copy of most current (less than 6 months old) Viral Load lab test results is needed to track client health outcomes; please attach a copy**

☐ **Oral Health Care (dental) referral: to ensure appropriate dental care treatment, please attach (or include with In Network or OON referral) a copy of most current (less than 6 months old) CD4 count, Viral Load, and complete blood count (CBC) test results, provide name of HIV antiretroviral medication(s), and complete the following:**

HIV Specialist / Primary Care Physician Name: _____

Phone Number: _____ Fax Number:_____

List Any Known Allergies:_____

List of HIV medications: _____