South Dakota Ryan White Part B Initial Program Application Form

Please complete as much information as possible. You will be contacted by a case manager within 1 week of this dated application to complete the full application for services. Please make sure the phone number is accurate!

You will need to provide proof of address, income, and HIV status when you meet with the case manager.

Name:			**Birth Date:**
Physical Address:		**City:**	**Zip Code:**
Gender:	**Race:**	**Hispanic/Latino** ☐ **Yes** ☐ **No**	**Best Contact Phone Number:**

Is this your phone ☐ **Yes** ☐ **No** **If "no" can we leave a message** ☐ **Yes** ☐ **No**

What is the best time to contact you? ☐ **Daytime** ☐ **Evening** ☐ **Anytime** ☐ **Specific Hours:** _____

Mailing Address: ***(leave blank if the same as physical address)***

Have you seen a doctor to treat your HIV in SD? ☐ **Yes** ☐ **No**	**If "yes" who is your current doctor?**
Diagnosis Date/State where diagnosed:	**Are you currently taking HAART?** ☐ **Yes** ☐ **No** **If "yes" what?**
Are you under 18 years old? ☐ **Yes** ☐ **No**	**Are you a veteran?** ☐ **Yes** ☐ **No** **Do you see a doctor at the VA?** ☐ **Yes** ☐ **No**

Insurance Coverage – Applicant Insurance Information ONLY

Do you currently have Dental Insurance Coverage? ☐ **YES** ☐ **NO**

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**

Did you recently lose health insurance coverage? ☐ **Yes** ☐ **No** **If "yes" when?**_____

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 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):_____

Reviewed April 2025