STAR PROGRAM SPECIAL TREATMENT AND RESEARCH

APPENDIX 2

Ryan White HIV/AIDS Program

APPLICATION FOR
SLIDING FEE DISCOUNT & CAP ON CHARGES

1. NAME: _____
   FIRST MIDDLE LAST Suffix (I, II, III, Jr, Sr. etc)

   ADDRESS: _____
   NUMBER AND STREET CITY STATE ZIP CODE

   TELEPHONE NO: _____

2. OCCUPATION: _____ RATE OF PAY: $_____/HOUR/WEEK/MONTH

   EMPLOYER: _____ ADDRESS: _____

3. HOSPITAL INSURANCE:_____POLICYNO:_____
   (NAME OF INSURANCE CO./GROUP PLAN)

4. DATE OF SERVICE:

   _____
   _____
   _____

5. TYPES & FREQUENCY OF SERVICES:

   _____
   _____
   _____

6. INCOME: LIST COMBINED INCOME FOR YOURSELF, SPOUSE AND OTHER DEPENDENTS:
   (PLEASE SUBMIT DOCUEMTATION)

	TOTAL BY MONTH	TOTAL FOR LAST 12 MONTHS
WAGES……	_____	_____
FARM OR SELF EMPLOYMENT…….	_____	_____
PUBLIC ASSISTANCE……..	_____	_____
UNEMPLOYMENT/WORKERS COMP……	_____	_____
STRIKE BENEFITS……..	_____	_____
ALIMONY/MAINTENANCE……..	_____	_____
CHILDSUPPORT……..	_____	_____
MILITARY FAMILY ALLOTMENTS……	_____	_____
PENSIONS……..	_____	_____
INVESTMENT INCOME (Dividends, Interest, etc)_____		_____
SOCIAL SECURITY DISABILITY(SSD)…….	_____	_____
SOCIAL SECURITY INCOME (SSI)…….	_____	_____
OTHER……..	_____	_____

TOTAL INCOME BY MONTH $_____ YEARLY_____

7. FAMILY SIZE: (USE BACK OF FORM IF MORE SPACE IS REQUIRED)

NAME	AGE	RELATIONSHIP
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____
Patient Signature Date

_____
Witness (if patient is unable to sign)

Review of Application

Based on the information provided, the above named patient is eligible for:

- ☐ Medicaid
- ☐ ADAP
- ☐ Medical Insurance through the New York Health Plan Marketplace
- ☐ Ryan White Sliding Fee Schedule (**indicate one below**)
  - ☐ Pending application for other insurance
  - ☐ Ineligible for other coverage

  Please Explain _____

  _____

  _____

  _____

_____ _____
Signature of CAC Date

_____
Print Name & Title