Referral for Ryan White Services

Referral to (agency name): _____ Date: _____

Client Name: _____

Referring Staff: _____ Referring Agency: _____ Staff Phone: _____

THE FOLLOWING CRITERIA MUST BE MET FOR SERVICES IN WHICH THE CLIENT DOES NOT PHYSICALLY GO TO THE PROVIDER TO RECEIVE SERVICES:

- ☐ *I, as the person making this referral, have ensured that eligibility and financial assessment have been conducted and all required documents are present and filed at the referring agency.*
- ☐ *I, as the person making this referral, have ensured that Ryan White funds are the payer of last resort. Based on the information provided by the financial assessment and the client's self-report, the client does not currently have the insurance or other sources of funding that could pay for this service.*
- ☐ *I, as the person making this referral, have ensured that the client has been informed of Client Rights and Responsibilities and the Client Grievance Process.*
- ☐ *I, as the person making this referral, have obtained basic registration information (see Basic Registration Information for Referrals form attached).*

Signature of Referring Staff: _____

REFERRAL TO THE FOLLOWING RYAN WHITE SERVICES:

Note: Referrals for Ryan White Oral Health Care services and Housing Services require different referral forms obtainable from provider.

- ☐ Emergency Financial Assistance for Medications (Under 400% FPL)
- ☐ Food Pantry (Under 150% of FPL and any Disability)
- ☐ Health Insurance Premium/Cost Sharing (Under 400% FPL)
- ☐ Home Delivered Meals (Under 150% of FPL and Homebound due to disability or unable to independently prepare meals)
- ☐ Legal Services (Under 75% of HUD low income limit)
- ☐ Medical Case Management

Medical Transportation (Under 150% FPL)

☐ Bus Passes ☐ ACCESS Coupon ☐ Van or Taxi Ride

Mental Health Services (Under 300% FPL)

☐ Individual Counseling ☐ Group Counseling

- ☐ Non-Medical Case Management
- ☐ Nutritional Supplements (Under 150% of FPL and any Disability)
- ☐ Outpatient/Ambulatory Medical Care

REFERRAL TO OTHER SERVICES (Please describe):

_____ _____

_____ _____

Notes: