TO: **SOUTHERN NEVADA DISTRICT BOARD OF HEALTH** **DATE:** **February 26 , 2026**

RE: *Approval of the Interlocal Agreement between the Southern Nevada Health District and Clark County, Nevada*

PETITION #19-26

That the Southern Nevada District Board of Health *approves the Interlocal Agreement (CBE NO. 607772-25), between the Southern Nevada Health District and Clark County, Nevada to collaborate on RYAN WHITE Part A JURISDICTIONAL CLINICAL QUALITY MANAGEMENT.*

PETITIONERS:

Cassius Lockett, PhD, *District Health Officer*
Lei Zhang, MS, *Public Health Informatics Manager*

DISCUSSION:

This is an agreement to support the cost of providing Clinical Quality Management (CQM) services for the Clark County area, in alignment with this scope of work and HRSA Policy Clarification Notice 15-02. Work completed will support the Las Vegas TGA's Clinical Quality Management Plan and related quality improvement projects.

FUNDING:

This agreement will provide funding to the SNHD for their collaboration in the CQM project. This is pass through funding from the Clark County supported by federal grant dollars for program period of March 1, 2026 through February 28, 2028, and is contingent upon receipt of grant funds awarded by HRSA to Clark County Social Service through the HIV Emergency Relief Project Grants award, number H89HA06900.

CBE NO. 607772-25

INTERLOCAL AGREEMENT FOR RYAN WHITE PART A JURISDICTIONAL CLINICAL QUALITY MANAGEMENT

This INTERLOCAL AGREEMENT hereinafter referred to as "AGREEMENT" is entered into on this _____ day of _____, 20_____ by and between CLARK COUNTY, Nevada, hereinafter referred to as "COUNTY" and SOUTHERN NEVADA HEALTH DISTRICT, hereinafter referred to as "SNHD" for RYAN WHITE PART A JURISDICTIONAL CLINICAL QUALITY MANAGEMENT.

W I T N E S S E T H:

WHEREAS, NRS 277.180 authorizes public agencies to contract with any one or more other public agencies to perform any governmental service, activity, or undertaking which any of the public agencies entering into the contract is authorized by law to perform;

NOW, THEREFORE, the parties mutually agree as follows:

ARTICLE I: SCOPE OF WORK

AGREEMENT sets forth:

1.0 Overview

The Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87) is the largest Federal program focused exclusively on HIV/AIDS care. The program is for individuals living with HIV/AIDS who do not have sufficient health care coverage or financial resources for managing their HIV. The Ryan White legislation has been adjusted with each reauthorization to accommodate new and emerging needs, such as an increased emphasis on funding of core medical services and changes in funding formulas. Funds are provided by the U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), Ryan White HIV/AIDS Treatment Extension Act of 2009 known as the Ryan White HIV/AIDS Program (RWHAP). The HIV Emergency Relief Grant Program Part A: Eligible Metropolitan Areas/Transitional Grant Areas HRSA Announcement No: HRSA-17-030 Catalog of Federal Domestic Assistance (CFDA) No. 93.914.

2.0 Scope of Project

COUNTY will provide Federal funds to SNHD to support the cost of providing Clinical Quality Management (CQM) services for the Clark County area, in alignment with this AGREEMENT and HRSA Policy Clarification Notice 15-02. Work completed will support the Las Vegas TGA's Clinical Quality Management Plan and related quality improvement projects.

Federal funds are provided by U.S. Department of Health and Human Services (DHHS), Health Resources and Services Administration (HRSA). Funds for program years March 1, 2026 through February 28, 2027 are contingent upon receipt of grant funds awarded by HRSA to Clark County Social Service through the HIV Emergency Relief Project Grants award, number H89HA06900.

3.0 Definitions and Common Abbreviations

Acquired Immune Deficiency Syndrome (AIDS) is the late stage of HIV infection that occurs when the body's immune system is badly damaged because of the virus. In the U.S., most people with HIV do not develop AIDS because taking HIV medicine every day as prescribed stops the progression of the disease. A person with HIV is considered to have progressed to AIDS when the number of their CD4 cells falls below 200 cells per cubic millimeter of blood (200 cells/mm3) or they develop one or more opportunistic infections regardless of their CD4 count. (In someone with a healthy immune system, CD4 counts are between 500 and 1,600 cells/mm3).

Clinical Quality Management (CQM) is the coordination of activities aimed at improving patient care, health outcomes, and patient satisfaction. All Ryan White HIV/AIDS Program recipients are required to establish clinical quality management programs to assess the extent to which HIV health services are consistent with the most recent Public Health Service guidelines for the treatment of HIV disease and related opportunistic infections; and develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV services.

Health Resources and Services Administration (HRSA) and the HIV/AIDS Bureau (HAB): The U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB) administers The Ryan White Program.

Human Immunodeficiency Virus (HIV) is a virus that attacks cells that help the body fight infection, making a person more vulnerable to other infections and diseases. It is spread by contact with certain bodily fluids of a person with HIV, most commonly during unprotected sex (sex without a condom or HIV medicine to prevent or treat HIV), or through sharing injection drug equipment. If left untreated, HIV can lead to the disease AIDS.

Out of Care references a client who doesn't have at least two HIV-related medical visits or laboratory tests (e.g., CD4 count or viral load), separated by at least 90 days, within a 12-month measurement period.

People With HIV (**PWH**) refers to infants, children, adolescents, and adults who have HIV.

Recipient (formerly referred to as the grantee) refers to COUNTY, specifically the Office of HIV at Clark County Social Service, to which grant funds from HRSA are directly awarded.

The Ryan White HIV/AIDS Treatment Modernization Act of 2009: The Ryan White CARE Act, "Title XXVI of the PHS Act as amended by the Ryan White HIV/AIDS Treatment Modernization Act of 2009", or "Ryan White Program" is the single largest federal program designed specifically for people with HIV/AIDS. First enacted in 1990, it provides care and treatment to individuals and families affected by HIV/AIDS. The Ryan White Program has five parts: Part A (formerly Title I) funds eligible metropolitan areas and transitional grant areas, 75 percent of grant funds must be spent for core services; Part B (formerly Title II) funds States/Territories, 75 percent must be spent for core services; Part C (formerly Title III) funds early intervention services, 75 percent must be spent for core services; Part D (formerly Title IV) grants support services for women, infants, children & youth and Part F comprises Special Projects of National Significance, AIDS Education & Training Centers (AETCs), Dental Programs and the Minority AIDS Initiative.

4.0 Deliverables

SNHD shall be responsible for completing the following:

1. Attendance and active participation in all Las Vegas TGA Clinical Quality Management meetings, lab data days and other CQM meetings and activities.
2. Monthly Out-of-Care reports that will support the Las Vegas TGA's Clinical Quality Management program's goal of increasing retention in care and viral suppression. The information provided in these reports will be utilized to re-engage people with HIV in medical care and supportive services.
    - On a monthly basis, COUNTY will share CAREWare data with SNHD to check against public health records to determine which clients meet the out-of-care definition.
    - Within 30 calendar days, SNHD will then send a report back to COUNTY with a list of all people with their medical care status (In care or out of care).
    - Data shall be transmitted securely between COUNTY and SNHD in MS Excel, CSV or similar format to ensure the COUNTY is able to identify people with HIV who are out of care.

Note: CQM activities **do not** include development of Service Standards; chart audits/reviews; monitoring site visits, if not to assess or monitor the CQM Program; extracting data for reporting to internal and external stakeholders (i.e. Ryan White Services Report (RSR); or electronic health records interface with other providers. These activities are considered administrative in nature and cannot be supported with CQM funds.

Allowable CQM activities **DO** include performance measurement prioritization and alignment with other RWHAP Parts in the service area; data extraction for clinical quality management purposes (collect, aggregate, analyze, and report on measurement data); monitoring site visits, if to assess or monitor the CQM Program; and CQM committee for planning for quality improvement projects. Data collected as part of administrative/quality assurance processes should feed back into the CQM program to ensure improvement in patient care, health outcomes, and patient satisfaction.

5.0 Responsibilities of SNHD

The purpose of this section is to provide a description of how SNHD is expected to utilize the allocated funding to provide the highest quality of service based on HRSA HAB guidelines and monitoring standards set forth to meet the necessary service provisions of the grant.

A. ***Program Administration, Development and Operations*** - SNHD shall:

- Ensure that, at minimum, the following personnel participate in Provider Orientation and subsequent refreshers provided by COUNTY: fiscal staff and program leadership.
- Ensure the PROGRAM is operated in accordance with:
  - Ryan White HIV/AIDS Program legislation.
  - HIV AIDS Bureau (HAB) Policy Clarification Notices (PCNs) and Program Letters.
  - Applicable Service Standards and Policies and Procedures of the Las Vegas Transitional Grant Area.
  - HAB National Monitoring Standards
  - Conditions of Award (COA) set forth by HRSA.
  - Terms and conditions set forth by HRSA in the applicable Notice of Funding Opportunity (NOFO).
  - Applicable Nevada Revised Statutes and Nevada Administrative Code.
  - All other applicable federal, state and local regulations.
- Ensure that SNHD, its officers, and employees are not debarred or suspended from doing business with the Federal Government.
- Employ personnel with sufficient technical knowledge, skill, and expertise necessary to complete the deliverables described in this AGREEMENT.
- Implement Administrative Safeguards and internal controls to prevent use or disclosure of protected Health Information as defined in the HIPPA Rules to protect and secure the confidentiality, integrity and availability of Electronic Protected Health Information. (45 CFR 164.308, 164.210 and 364312) in accordance with 45 CFR 164.316.
- Notify COUNTY of any attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with system operations in an information system as is defined in SNHD's Security Incident Management Plan and this paragraph ("Security Incident") within 24 hours of discovery of the incident. Incidents that can be characterized as a "single series of unwanted or unexpected information security events that have a significant probability of compromising business operations and threatening information security" will be subject to such notification.
- Build organizational and personnel capacity by using and cultivating understanding of program requirements through web-based resources, modules, manuals, materials and videos available on the Las Vegas TGA website's Learning Portal and "Sub Award Resources" section.
- Request support and technical assistance from COUNTY as needed.

B. **Fiscal** - SNHD shall:

- Submit to COUNTY'S authorized representative a monthly Request for Reimbursement by the 15th calendar day of each month for the previous month's services.
- Establish such fiscal and accounting procedures necessary to ensure:
  - The proper disbursal of, and account for grant funds in order to ensure that all financial transactions are conducted.

- Maintain financial records pertaining to all matters relative to this AGREEMENT in accordance with standard accounting principles and procedures and retain all records and supporting documentation applicable for a period of five (5) years upon completion or termination of this AGREEMENT, whichever comes first.
- Delineate how multiple funding sources for services are allocated appropriate for its designated intended service. All such records relating to any analysis or audit performed relative to this AGREEMENT shall be retained for five (5) years after such analysis or audit has been performed and any findings have been resolved.
- In the event that SNHD no longer operates within the Las Vegas Transitional Grant Area (Clark County, NV; Nye County, NV or Mohave County, AZ), it shall be required to deliver a copy of all records relating to this AGREEMENT with COUNTY to be retained by COUNTY and SNHD.

6.0 Responsibilities of COUNTY:

COUNTY shall ensure that all clients participating in programs offered by its Office of HIV at Clark County Social Service under Ryan White Part A programs funded by HRSA complete a Universal Eligibility Application, a blank copy of which is attached hereto as Exhibit A, and which in relevant part, will authorize SNHD to share sensitive information concerning COUNTY clients with COUNTY as is required under this AGREEMENT**.**

7.0 References

- **HRSA Ryan White HIV/AIDS Program**
  https://hab.hrsa.gov/
- **Las Vegas TGA, Ryan White Service Standards and Policies & Procedures**
  https://lasvegastga.com/standards/; https://lasvegastga.com/quality-management-2/
- **Clinical Quality Management Policy Notification Notice 15-02**

  https://hab.hrsa.gov/sites/default/files/hab/Global/HAB-PCN-15-02-CQM.pdf
- **Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds**
  https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf

8.0 Attribution

This program is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $7,551,492.00 with 0% percentage financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.

ARTICLE II: TERM OF AGREEMENT

The initial term of AGREEMENT shall be from March 1, 2026 through February 28, 2028.

Notwithstanding the foregoing provision, either party may terminate AGREEMENT, without cause, upon giving thirty (30) days written notice to the other party. In the event the Budget Act and Fiscal Fund Out provision is invoked, AGREEMENT shall expire June 30th of the then current fiscal year. Termination due to the failure of COUNTY or SNHD to appropriate monies shall not relieve the parties' obligations under AGREEMENT incurred through June 30th of the fiscal year for which monies were appropriated for their operations.

ARTICLE III: PRICE, PAYMENT, AND SUBMISSION OF INVOICE

COUNTY will reimburse SNHD for goods and/or services provided as outlined in Article I – Scope of Work.

Remuneration will remain on a reimbursement basis unless specifically waived by COUNTY. Reimbursement will be paid after eligible expenses have been incurred and expended in conformance to Article I - Scope of Work.

The table below reflects the budget that corresponds to Article I - Scope of Work for FY26 and FY27 grant years:

Description	Total
Jurisdictional Clinical Quality Management 3/1/26-2/28/27	$45,000.00
Jurisdictional Clinical Quality Management 3/1/27-2/29/28	$50,000.00
TOTAL	**$95,000.00**

COUNTY'S obligation to pay SNHD cannot exceed this amount. It shall be the SNHD'S responsibility to ensure the hours and tasks are properly budgeted, so the entire program is completed for the said fixed fee. SNHD shall submit to COUNTY a monthly invoice and summary of services in a format provided by COUNTY.

If COUNTY rejects an invoice as incomplete, SNHD will be notified within thirty (30) calendar days of receipt and AGENCY will have thirty (30) days to correct the invoice and resubmit.

Invoices shall be submitted via email at: CCHIVFiscal@ClarkCountyNV.gov

SNHD must notify COUNTY in writing of any changes to SNHD'S remit payment address or other pertinent information that may affect issuance of payment and allow thirty (30) days for the change to be processed.

COUNTY is not responsible for late payments on inaccurate invoices and/or incomplete or unsatisfactory deliverables or milestones. COUNTY does not pay late fees or charges. Final payment may be withheld until all deliverables have been submitted and accepted or final services have been rendered.

ARTICLE IV: FISCAL FUNDING OUT CLAUSE

In accordance with the Nevada Revised Statutes (NRS 354.626), the financial obligations under AGREEMENT between the parties shall not exceed those monies appropriated and approved by COUNTY for the then current fiscal year under the Local Government Budget Act. AGREEMENT shall terminate and COUNTY'S obligations under it shall be extinguished at the end of any of COUNTY'S fiscal years in which COUNTY'S governing body fails to appropriate monies for the ensuing fiscal year sufficient for the payment of all amounts which could then become due under AGREEMENT. COUNTY agrees that this section shall not be utilized as a subterfuge or in a discriminatory fashion as it relates to AGREEMENT. In the event this section is invoked, AGREEMENT will expire on the 30th day of June of the current fiscal year. Termination under this section shall not relieve COUNTY of its obligations incurred through the 30th day of June of the fiscal year for which monies were appropriated.

ARTICLE V: AMENDMENT / ENTIRE AGREEMENT

Amendment to AGREEMENT may be made only upon mutual consent in writing, by the parties hereto and executed with the same formality attending the original. Executed AGREEMENT, together with any attachments, contains the entire agreement between COUNTY and SNHD relating to the rights granted and obligations assumed by the parties hereto. Any prior agreements, promises, negotiations or representations, either oral or written, relating to the subject matter of agreement not expressly set forth in AGREEMENT are of no force or effect.

ARTICLE VI: SUBCONTRACTS

AGREEMENT is entered into to secure the services of SNHD. Services specified in this AGREEMENT shall not be subcontracted by SNHD without the written consent of COUNTY.

ARTICLE VII: ASSIGNMENTS

Neither party may assign or delegate all or any part of AGREEMENT without the written consent of both parties and executed with the same formality as attending this original.

ARTICLE VIII: NOTICES

Any notice required or permitted to be given hereunder shall be in writing and shall either be delivered personally to the party to whom such notice is given, or sent to it by United States registered or certified mail, postage prepaid and return receipt requested, addressed or delivered to such party at the address or addresses designated below (or such other address or addresses as may hereafter be designated by a party) by written notice to the other party:

To COUNTY:
Attention: Heather Shoop
Clark County Social Service – Office of HIV
1600 Pinto Lane
Las Vegas, Nevada 89106

To SNHD:
Attention: Sr. Contract Administrator, Legal Dep
Southern Nevada Health District
280 S. Decatur Blvd
Las Vegas, Nevada 89107

With a copy to:
Attention: Lei Zhang
Southern Nevada Health District
Office of Informatics
280 S. Decatur Blvd.
Las Vegas, Nevada 89107

ARTICLE IX: POLICIES AND PROCEDURES

SNHD agrees to abide by all quality assurance, utilization review, peer review and consultation, standardized reporting, credentialing, and policies and procedures mutually established by COUNTY and SNHD.

ARTICLE X: INSURANCE

SNHD, at its own expense, agrees to obtain and maintain in full force and effect during the term of this AGREEMENT, insurance in commercially reasonable amounts calculated to protect itself and the COUNTY from any and all claims of any kind of nature for damage to property or personal injury, including death, made by anyone, that may arise from activities performed or facilitated by this AGREEMENT. Such insurance shall include medical malpractice coverage on SNHD'S employees and officers as applicable.

ARTICLE XI: WAIVER AND SEVERABILITY

Any waiver of a breach of any provision of AGREEMENT shall not be deemed a waiver of any other breach of the same or different provision. In the event any provision of AGREEMENT is rendered invalid or unenforceable by any valid act of Congress or the Nevada State Legislature or declared null and void by any court of competent jurisdiction or is found to be in violation of State Statutes and/or regulations, said provision(s) hereof will be immediately void and may be renegotiated for the sole purpose of rectifying the non-compliance. The remainder of the provisions of AGREEMENT not in question shall remain in full force and effect.

ARTICLE XII: LAW OF VENUE

AGREEMENT shall be governed by the laws of the State of Nevada.

ARTICLE XIII: SUSPENSION AND TERMINATION

Suspension. COUNTY may suspend performance by SNHD under this AGREEMENT up to 90 calendar days as COUNTY, at its sole discretion, may prescribe by providing written notice to SNHD. SNHD shall not perform further work under this AGREEMENT as of the effective date of suspension. SNHD may not resume performance, unless and until, COUNTY issues written notice to resume performance.

Termination for Convenience. Either party has the right to terminate this AGREEMENT for convenience by giving the other party hereto thirty (30) calendar day's written notice of intent to terminate.

Termination for Cause. This AGREEMENT may be terminated for cause by either party in the event of substantial failure of the other party to fulfill its obligations under this AGREEMENT through no fault of the terminating party; but only after the other party is given not less than thirty (30) calendar days written notice of intent to terminate; and an opportunity for consultation with the terminating party prior to termination. Neither party shall be considered in default in the performance of its obligations hereunder, to the extent that performance of such obligations is prevented or delayed by any cause, existing or future, which is beyond the reasonable control of such party. Delays arising from the actions or inactions of one or more of SNHD'S principals, officers, employees, agents, subcontractors, vendors or suppliers are expressly recognized to be within SNHD'S control. If after termination for cause it is determined that SNHD has not so failed, the termination shall be deemed to have been effected for the convenience of COUNTY.

Process. The rights and remedies of COUNTY and SNHD provided in this section are in addition to any other rights and remedies provided by law or under this AGREEMENT.

1. Upon receipt by SNHD of a suspension or termination notice, or delivery by SNHD of a termination notice, SNHD shall promptly discontinue all services affected (unless COUNTY'S notice directs otherwise) and deliver or otherwise make available to COUNTY, copies of all deliverables completed pursuant to the schedule set forth in Article I - Scope of Work.
2. In the event this AGREEMENT is terminated by SNHD, SNHD acknowledges that its termination may affect COUNTY'S consideration of SNHD for future projects.
3. In the event of termination of this AGREEMENT, SNHD is eligible for compensation earned based on actual costs or the percentage of work completed, as fairness dictates, less all previous payments. COUNTY will pay SNHD for work performed up to and including the date on which SNHD discontinued or should have discontinued all services as determined by paragraph 1. No payment shall be allowed for anticipated profit on performed or unperformed services or other work. Any payment due to SNHD may be adjusted to the extent COUNTY incurs additional costs by reason of SNHD'S default. The final invoice for all work completed as of the date of termination, shall be received by COUNTY within sixty (60) calendar days after date of termination.
4. Upon termination, COUNTY may take over the work and prosecute the same to completion by contract with another party or otherwise.

(Left Blank Intentionally and Signatures on Next Page)

IN WITNESS WHEREOF, the parties hereto have caused AGREEMENT to be signed and intend to be legally bound thereby.

COUNTY OF CLARK:

BY: _____
JESSICA COLVIN
Chief Executive Officer

DATE: _____

ATTEST:

BY: _____
LYNN MARIE GOYA
County Clerk

DATE: _____

APPROVED AS TO FORM:
Steven Wolfson, District Attorney

BY: _____
SARAH SCHAERRER
Deputy District Attorney

DATE: _____

SOUTHERN NEVADA HEALTH DISTRICT:

BY: _____
CASSIUS LOCKETT, PHD
District Health Officer

DATE: _____

APPROVED AS TO FORM:
This document is approved as to form.
Signatures to be affixed after approval by
Southern Nevada District Board of Health

BY: _____
HEATHER ANDERSON-FINTAK, ESQ.
General Counsel
Southern Nevada Health District

DATE: _____

EXBIHIT A

Nevada Ryan White All Parts Common Guidance Document 18-04A Universal Eligibility Application

Application Date: _____ ☐ Initial Application ☐ Annual Recertification

For Administrative Use Only:
New Ryan White Eligibility: Start Date: _____ End Date: _____
Case Manager/ Eligibility Specialist Name: _____
Subrecipient Agency: _____

CONTACT INFORMATION

Legal Last Name:	**Legal First Name:**		**Middle Name:**	
***Birth Date:**		**Preferred Name or AKA and Pronouns:**		
Language Preference: ☐English ☐ Spanish ☐ Other: _____ In Need of a Translator: Yes ☐ No ☐		**SSN or TIN (Optional)**		
Home Address:		**City:**	**State:**	**Zip:**
Mailing Address *(if different than home):*		**City:**	**State:**	**Zip:**
1. Phone – include area code:	**Type:**	**May we contact you by phone?** ☐ **Yes** ☐ **No**		
2. Phone – include area code:	**Type:**	**May we leave a message?** ☐ **Yes** ☐ **No**		
E-mail Address:	**May we E-Mail you?** ☐ Yes ☐ No	**May we contact you by mail?** ☐ **Yes** ☐ **No**		
		Should mail be confidential? ☐ **Yes** ☐ **No**		

SECONDARY CONTACT

Name:	**Phone – include area code:**	**Relation to the Client?**	
Address:	**City:**	**State:**	**Zip:**
Notes/Comments:	**Is the Secondary Contact Aware of client's status?** ☐ Yes ☐ No		

DEMOGRAPHICS

***What sex were you assigned at birth, such as your original birth certificate? (Mark One Answer)**
☐ Male
☐ Female

***Race/Ethnicity:** ☐ White ☐ Black/African American ☐ American Indian/Alaskan Native ☐ Native Hawaiian/Pacific Islander (*if checked, choose an option below)* ☐ Native Hawaiian ☐ Guamanian/Chamorro ☐ Samoan ☐ Other Pacific Islander: _____ ☐ Asian (*if checked, choose an option below)* ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian: _____	***Race/Ethnicity:** ☐ Non-Hispanic/Latino ☐ Hispanic/Latino, (*if checked, choose an option below)* ☐ Mexican, Mexican American, Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other Hispanic: _____ ☐ Middle Eastern ☐ North African ☐ Other: _____

Relationship Status: ☐ Single ☐ Married ☐ Domestic Partnership ☐ Unmarried Couple ☐ Divorced ☐ Separated ☐ Widowed

Are you a veteran? ☐ Yes ☐ No

PROOF OF DIAGNOSIS (COMPLETED ONLY DURING INITIAL APPLICATION)

All clients must provide upon **initial enrollment only** one (1) medical/legal document from the list below indicating HIV infection. **Documentation must contain the client's full name**. Please select *one* option from the list below and **attach a copy** to this application

Proof of Diagnosis Documents
☐ Western Blot
☐ Letter on physician's letterhead, with signature of doctor, indicating that the applicant is HIV positive with diagnosis date.
☐ Electronic medical record from physician's office, with electronic signature of doctor, indicating that the applicant is HIV positive.
☐ Positive HIV test (immunoassay) and detectable viral load (HIV RNA)
☐ Two positive HIV tests (immunoassays- should be different assays based on different antigens or different principles)
☐ Request for Proof of Diagnosis Form completed by applicant's physician (CGD 15-39)

HIV/AIDS STATUS/DIAGNOSIS INFORMATION/RISK FACTORS (COMPLETED ONLY DURING INITIAL APPLICATION)

***HIV/AIDS Status:** ☐ HIV Positive (not AIDS) ☐ HIV Positive (AIDS status unknown) ☐ CDC Defined AIDS
☐ HIV Negative (Affected) ☐ HIV Indeterminate (infants <2 years old)

***Date of First HIV+ Diagnosis:**	☐ **Estimated?**	***Date of First AIDS Diagnosis:**	☐ **Estimated?**

How do you believe you acquired HIV?

☐ Male to Male sexual contact
☐ Injection Drug Use
☐ Male to Female Sexual Contact
☐ Hemophilia/Coagulation Disorder
☐ Recipient of transfusion of blood, blood components, or tissue
☐ Perinatal Transmission
☐ Undetermined/Unknown, risk not reported or identified
☐ Other, please specify: _____

BASIC MEDICAL

How do you obtain primary HIV medical care?

☐ Publicly funded clinic or health district
☐ Private Practice
☐ Emergency Room
☐ Hospital Outpatient Center
☐ No primary source of care
☐ Other: _____

Primary Care Physician Name:	**HIV Specialist Name:**

RESIDENCY

***What is your current housing status?**

☐ I live in stable housing (includes HOPWA): ☐ Rent ☐ Own ☐ Long-Term Care Facility
☐ I live in temporary housing: ☐ Friends/Family (including couch-surfing) ☐ Hotel/Motel ☐ Transitional Housing or Treatment Center
☐ I live in unstable housing: ☐ Homeless/Emergency Shelter ☐ Jail/Prison/Detention Facility

All clients must provide one (1) residency document from the list below indicating Nevada residency.

- Please select *one* option from the list below and **attach a copy** to this application
- ***If your address changes at any time, please contact an Eligibility Specialist or Case Manager to update your address***

Residency Documentation	
☐ Current Lease/Rental Agreement	☐ Current Nevada Driver's License or State ID Card
☐ Rent/Mortgage Receipt (dated within the past 30 days)	☐ Consulate Identification Card
☐ Any Bill, Invoice, or Correspondence (dated within the past 30 days)	☐ Resident Alien Card
☐ Paycheck Stubs with Your Address	☐ Proof of Property Taxes Paid
☐ Letter from a Government Agency	☐ Voter Registration/Vehicle Registration
☐ Other Verifiable Government-Issued ID with Address	☐ Prison Release Papers
☐ Dependent Support Form (CGD 15-48) or a Letter: *See below*	☐ I am Homeless: *Complete the Attestation of Homelessness Below*
☐ Verification of Residence (CGD 15-50) or a Letter from Landlord	

If you cannot provide residency proof in your own name, please complete the Dependent Support Form (CGD 15-48) or submit a letter with your current address and a signature of person(s) providing support.

Attestation of Homelessness

I attest that I am homeless or living in a shelter with no verifiable residence. I agree that if my residency status changes, I must immediately notify the Ryan White Part All Parts (ABCD) eligibility agency and provide documentation of residency.

Client Signature: _____ Date: _____

HOUSEHOLD SIZE

List members of your household, such as a legal spouse and children who live with you, ***and*** anyone you will claim as a dependent on your taxes. *Please list yourself first.*

Client or Family Member Name	Relationship to Client	Does this person have Taxable Income?	Over age 18?	Claimed on Taxes?
	Self	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Total Household Size: _____

INCOME

Proof of household income is based on Modified Adjusted Gross Income (MAGI). Household income includes all income of anyone the client claims on their taxes or the income of someone who claims the client as a dependent on their taxes.

All clients and household members listed above must provide proof of income documentation from the list below, if applicable.

- ***If your income changes at any time, please contact an Eligibility Specialist or Case Manager to update your income.***

Income Source Documentation

Please select *all* income options that apply to your household from the list(s) below.

☐ Paycheck Stubs or Employment Statement for the last month *(most recent)*
☐ Annual Award Letter: Social Security, Supplemental Social Security (SSI), Social Security Disability Income (SSDI), Veterans Benefits, Annual Pension, Retirement, etc.
☐ Other Award Letter: Temporary Assistance for Needy Families (TANF), Unemployment, Child support/alimony etc.
☐ One (1) Month of Bank Statements *(only if pay stubs or annual statements cannot be provided)*
☐ Pre-Paid Debit Card Statements
☐ Profit and Loss Statement from Self-Employment (CGD 16-04)
☐ Other Source of Income: _____
☐ No Income: *Complete the Attestation of No Income Below*

Non-Taxable Income Sources

Do you, or anyone in your household, have any types of non-taxable income sources?

☐ No, I nor anyone in my household has non-taxable income sources.
☐ Yes, I or someone in my household has non-taxable income sources *(check all that apply - documentation must be provided)*

- ☐ Supplement Social Security Income (SSI)
- ☐ Workers Compensation
- ☐ Child Support (Received)
- ☐ Veteran's Disability Income
- ☐ Proceeds from Loans (Student/Bank Loans)
- ☐ SNAP (Food Stamps)
- ☐ WIC (Women, Infants and Childrens Program
- ☐ Housing Subsidies (e.g. Section 8 Vouchers, HUD Housing, HOPWA)
- ☐ Utility or Energy Assistance
- ☐ Child Care Assistance/Subsidies
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

Monthly Self $ _____ **Monthly Spouse/Household $**_____

Taxable Income Sources

Do you, or anyone in your household, have any of the following types of taxable income sources?

☐ No, I nor anyone in my household has taxable income sources

☐ Yes, I or someone in my household has a taxable income source *(check all that apply – documentation must be provided)*

- ☐ Wages, Salary, & Tips (Gross- before taxes)
- ☐ Social Security Retirement Income
- ☐ Social Security Disability Income
- ☐ Business / Self Employment Income
- ☐ Taxable Interest and Dividends
- ☐ Capital Gains
- ☐ Rental Income (Net)
- ☐ Unemployment Compensation
- ☐ Taxable amount from Pensions & IRAs Distributions
- ☐ Other income not exempted (Jury Duty Pay, Gambling Winnings)

Monthly Self (before taxes) $ _____ **Monthly Spouse/Household (before taxes) $** _____

How often are you or your spouse/household member paid?

Every Week:	☐ Self	☐ Spouse/Household
Every Two Weeks:	☐ Self	☐ Spouse/Household
Semi Monthly- *The 15th and 30th of the Month*:	☐ Self	☐ Spouse/Household
Monthly:	☐ Self	☐ Spouse/Household
Unstable Income:	☐ Self	☐ Spouse/Household

Deductions

Do you, or anyone in your household, have any of the following types of deductions?

☐ No, I nor anyone in my household has deductions.

☐ Yes, I or someone in my household has deductions *(check all that apply – documentation must be provided)*

- ☐ Health Savings Account Deductions
- ☐ Self-Employment Health Insurance Costs
- ☐ Health Costs (Insurance Premiums- Paid by Self)
- ☐ Workplace Retirement Plan: 401K
- ☐ Workplace Retirement Plan: 403B
- ☐ Traditional IRA (not a Roth IRA)

Monthly Self (before taxes) $_____ **Monthly Spouse/Household (before taxes) $** _____

FOR ADMINISTRATIVE USE ONLY

Monthly MAGI Income Formula: Monthly Taxable Income Sources minus (-) Monthly Deductions

For taxable income, follow these instructions to calculate monthly MAGI income:

- *If the individual is Paid Every Week, Every Two Weeks, or has Unstable Income: 1) Add the individual's checks together for the 30-day period, 2) Divide that by the number of checks to calculate an average, 3) Multiply the average by, 4.3 if paid weekly, or 2.15 if paid every two weeks. Repeat for each applicable individual (spouse or household member)*
- *If the individual is Paid Semi-Monthly: Add the two amounts together. Repeat for each applicable individual (spouse or household member).*
- *If the individual is Paid Monthly: No calculation is needed.*

Monthly MAGI Income: Self **$** _____ Spouse/Household **$** _____ *Note: (Non-Taxable Income is not included in MAGI)*

Annual MAGI Income: $_____

Attestation of No Income

I attest that I have no verifiable income. I agree that if my financial status changes, I must immediately notify the Ryan White Part All Parts (ABCD) eligibility agency and provide documentation of income.

I am receiving financial assistance with food, water, and basic needs from: _____

Client Signature: _____ Date: _____

HEALTH INSURANCE

Do you need assistance enrolling in insurance, paying your health insurance premiums, and/or medications? ☐ Yes ☐ No

Select all of the health insurance types you have, then complete all of the sections below:

☐ Medicaid
☐ Medicare Parts A/B/C/D/Supplement
☐ Private- Individual (Direct Purchase/ Marketplace/ COBRA)
☐ Private- Employer
☐ Veterans' Health Administration (VA), TRICARE, CHAMPVA
☐ Indian Health Service (IHS)
☐ Other Health Insurance: _____
☐ **No Health Insurance**

Medicaid

Are you enrolled in Medicaid?

☐ Yes, I am enrolled in Medicaid Plan Name: _____
☐ I applied, but I was denied. Reason: _____
☐ I applied, but I am awaiting a decision.
☐ No, I am not enrolled because:
- ☐ I have other health insurance.
- ☐ I am not eligible; my income and assets exceed Medicaid eligibility requirements.
- ☐ I need a referral to Medicaid.
- ☐ My income is below 138% of the Federal Poverty Level (FPL), but I am declining a referral to Medicaid

Medicare

Are you enrolled in Medicare?

☐ Yes, I am enrolled in Medicare *(check all that apply)*
- ☐ Part A
- ☐ Part B
- ☐ Part C/ Medicare Advantage Plan/ Health Plan Plan Name: _____
- ☐ Part D/ Drug Plan Plan Name: _____
- ☐ Medicare Supplement or Retirement Plan Plan Name: _____

☐ No, I am not enrolled in Medicare.
☐ If you are enrolled in Medicare, do you receive Extra Help/ Low-Income Subsidy for your prescription drug costs? ☐ Yes ☐ No

Marketplace/ Nevada Health Link

Are you enrolled in a Marketplace Plan/ Nevada Health Link?

☐ Yes, I am enrolled in a Marketplace Plan/ Nevada Health Link Plan Name: _____
☐ I applied, but I was denied. Reason: _____
☐ I applied, but I am awaiting a decision.
☐ No, I am not enrolled because:
- ☐ I have other health insurance.
- ☐ I am waiting for the open-enrollment period.
- ☐ I need a referral to an insurance specialist for enrollment into a Marketplace Plan
- ☐ My income is between 139% and 400% of the Federal Poverty Level (FPL), but I am declining a referral to the Marketplace

Private or Employer Health Insurance

Are you enrolled in a private or employer-based health insurance plan?

☐ Yes, I am enrolled *check all that apply Plan Name: _____
- ☐ Employer Plan
- ☐ COBRA
- ☐ Spouse/ Domestic Partner/ Parent
- ☐ Private- Individual Plan (not Marketplace)

☐ No, I am not enrolled because:
- ☐ I have other insurance.
- ☐ I am waiting for my employer's open-enrollment period.
- ☐ I am not employed.

☐ No, I am not enrolled, but I may be able to get insurance through: ☐ Employer ☐ Spouse/ Domestic Partner/ Parent ☐ COBRA

If you or your spouse are employed and you are requesting premium or prescription assistance, you will be contacted by ADAP staff to complete the Employer Benefit Verification Form.

RYAN WHITE AND OTHER SERVICE NEEDS

Are you consistently taking your medications as prescribed?	☐ Yes	☐ No
Do you need counseling or education about your medications?	☐ Yes	☐ No
Do you need counseling or education about Risk Reduction?	☐ Yes	☐ No
Do you have issues with stress and/or depression in your life?	☐ Yes	☐ No

Which Ryan White Services do you need?

☐ Assistance with Food and Meals	☐ Legal Services	☐ Psychosocial Support/ Support Groups
☐ Case Management	☐ Medical Copayment Financial Assistance	☐ Substance Use Therapy
☐ Dental Care	☐ Medical Nutrition Therapy (Dietician)	☐ Transportation Assistance
☐ Emergency Financial Assistance (Utilities, Rent)	☐ Medication Assistance	☐ Treatment Adherence
☐ Health Education/Risk Reduction	☐ Mental Health Therapy	☐ Vision Care
☐ Health Insurance Premium Assistance	☐ Prenatal Care	☐ Other: _____
☐ Housing Assistance	☐ Primary or Specialty Medical Care	☐ Other: _____

RIGHTS AND RESPONSIBILITIES

The following statements reflect your rights and responsibilities as an individual seeking medical and support services from Ryan White All Parts (ABCD) Programs in the State of Nevada.

Client Rights

1. **Respect, Courtesy, and Privacy:** *You have the right to be treated at all times with respect and courtesy within a setting which provides you with the highest degree of privacy possible.*
2. **Freedom from Discrimination:** *You have the right to freedom from discrimination because of race, color, religion, sex, sexual orientation, gender identity or expression, age, disability, veteran's status, or national origin.*
3. **Access to HIV/AIDS Service Information:** *You have the right to be informed by your health care and/or social service provider about the full range of available HIV/AIDS treatments and about related available social and support services. You have the right to be advised of the risks and to discuss the benefits of any proposed treatments/services. You have the right to give your informed consent to any treatments/services or services before they are provided.*
4. **Identity and Provider Credentials:** *You have the right to know the names, titles, specialties, and affiliations of all health and social service providers, and anyone else involved in your care. You have the right to know about the health or social service organization's policies and procedures.*
5. **Culturally Sensitive Sharing of Information:** *You have the right to have information shared with you in a respectful manner that is easy to understand and takes into account the differences in each person's background, culture, and preferences.*
6. **Consent and the Care Plan:** *You have the right to be involved in the development of an individualized plan of care prior to and during the course of treatment. You have the right to disagree, change your mind, or request a medical second opinion without affecting the ongoing availability of treatment/services.*
7. **Choice and Access to Service:** *You have the right to be informed of all available services upon intake. You have the right to choose and receive all treatments/services for which you qualify.*
8. **Declining Service:** *You have the right to decline treatments/services without pressure from your healthcare or social service provider. You have the right to refuse to participate in any research studies or experiments that the provider may recommend. You have the right to change your mind after refusing or consenting to treatment, clinical trials, counseling, or any other service without affecting ongoing care.*
9. **Naming an Advocate:** *You have the right to choose an advocate. You may have more than one advocate (such as a family member or another person) to give you support and represent your rights.*
10. **An Advanced Directive for Care:** *You have the right to have advance directives, such as a Living Will, Healthcare Proxy, or Durable Power of Attorney for health and social services.*
11. **Access to Financial Information:** *You have the right to ask questions about and see all of your health care bills. You have the right to get referrals and help with any payment problems.*
12. **Confidentiality and Access to Records:** *You have the right to have all of your records kept strictly confidential, and not released without your permission. You have the right to access all of your records, unless the information is expressly excluded as outlined in HIPPA (Health Insurance Portability and Accountability Act), and to have copies of these at a fair copying cost.*
13. **Transferred and Continuity of Care:** *You have the right to uninterrupted treatments/services. If possible, your requests to leave one provider and be seen by another should be honored and happen as soon as possible. You may NOT be transferred to another provider or facility without an explanation for the transfer. You must be informed of other options that are available.*
14. **A Client Grievance Procedure:** *You have the right to voice complaints, to suggest changes, and to be informed about how to file a grievance (a formal written complaint). You have the right to do this without harassment, interference or pressure. You have the right to request a copy of an agency's grievance policy and procedures. You have the right to contact the Ryan White Recipient Offices to appeal an agency's decision about your grievance or at any point should you feel that the agency is not responsive to your grievance.*

Initials: _____

Client Responsibilities

1. **Respect, Courtesy, and Confidentiality:** *Health and social service providers have the right to be treated with respect and courtesy at all times.*
2. **Giving Correct and Complete Information**: You *are responsible for giving your provider accurate and complete information; you must give this information to the best of your ability. You are responsible for giving accurate and complete information about third party payers (such as insurance companies, Medicaid, Medicare) to your providers and their facilities*
3. **Seeking Facts About Your Case:** *You are responsible for asking questions about the care you are receiving if you do not completely understand*
4. **Following Treatment Plans:** *You are responsible for following treatment plans that you and your providers have agreed upon. You have the responsibility to tell your provider right away if you decide to stop your treatment or go against your provider's advice.*
5. **Scheduled Appointments:** *You are responsible for keeping appointments that you and your provider have scheduled. If you have to cancel, you are responsible for notifying your provider.*
6. **Rules and Regulations of Service Provider Organizations: You** *are responsible for following the rules and regulations of your providers and their agencies/facilities.*
7. **Voicing Complaints and Grievances:** *You are responsible for voicing complaints and presenting grievances in a courteous, appropriate, and timely manner. You should do this by following the provider's grievance policy and procedure, and you may ask for help in doing this if you need it. You are responsible to appeal an agency's decision about your grievance to the Ryan White Recipient Offices or to contact the Recipient Offices if you feel the agency is not responsive to your grievance.*

Initials: _____

RELEASE OF CONFIDENTIAL INFORMATION

I hereby authorize any of the agencies listed below who participate in the community-based Ryan White All Parts (ABCD) Programs and HOPWA Programs in the State of Nevada to release and/or share information concerning my eligibility, medical record status, and information concerning my diagnosis and treatment. The following agencies/programs authorized are:

- ACCEPT
- Access to Healthcare Network
- Aid for AIDS of Nevada
- AIDS Healthcare Foundation
- Asian Community Resource Coalition of Las Vegas
- Carson City Health and Human Services
- CAN Community Health
- Chicanos Por La Causa Nevada, Inc.
- Community Health Alliance
- Central Nevada Health District
- City of Las Vegas- HOPWA
- Clark County Social Service
- Community Counseling Center
- Community Outreach Medical Center
- Dignity Health
- Division of Public and Behavioral Health HIV Surveillance
- Golden Rainbow of Nevada, Inc
- Kirk Kerkorian School of Medicine / UNLV Health
- Maternal Child Wellness Program
- Ramsell Corp– Pharmacy Benefits Manager
- Medicare
- Nevada Division of Welfare and Supportive Services
- Nevada Health Authority
- Nevada Legal Services
- North Country Healthcare
- Northern Nevada HOPES
- Northern Nevada Public Health
- Nye County Health & Human Services
- REACH
- Southern Nevada Health District
- The Gay & Lesbian Center of Southern Nevada
- The Just One Project
- University Medical Center
- Vegas Stronger
- Women's Development Center

- Your Health Insurance Company: _____
- Your Physician: _____
- Partner/Spouse/Other: _____

Information may be released between the above listed agencies throughout the duration of my active enrollment in the Ryan White All Parts (ABCD) program. Only agencies at which I have sought or will seek services will have access to my shared information. I understand that my records are protected under federal HIPAA regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I may revoke this consent in writing any time, except to the extent that any action has been taken or services were rendered while it was or s still in force. I understand that by choosing to withdraw and I am no longer seeking services from Ryan White All Parts (ABCD) program. This consent expires automatically one (1) year from registration or previously signed consent.

ACKNOWLEDGEMENT

I fully understand that by applying for this program, I am divulging personal information that will be used to assist me with benefits associated with the Nevada Ryan White Parts A, B, C, D Programs. I understand this information will be kept confidential but will be used by staff to review my eligibility for this program. Also, by signing this form, I understand that the information contained within may be used to verify all application information provided. By applying for this program, I understand that this does not mean that my application will be accepted, as funds are limited, and eligibility requirements must be met.

I fully acknowledge:

1. **It is my responsibility to renew my eligibility every 6 months on or before my birth month and 6 months following (half-birth month).**
2. **It is my responsibility to report any changes to my household income, my address, my contact information, my health insurance, or any other information that may affect my eligibility or services.**
3. **If I fail to recertify, my eligibility and benefits will be suspended.**

I certify that the information provided in this application is true and accurate as of the date below and acknowledge that any intentional or negligent misrepresentation of the information may result in nullification of this application and a termination of benefits.

Client Printed Name	**Client Signature**	**Date**
Printed Name of Representative	**Signature of Representative**	**Date**