Authorization/Application for Ryan White Part C Program

Ryan White Part C may be able to assist with the cost of office visits, outpatient labs, specialty care, dental, and mental health services, and/or immunizations. Bills will be assessed on an individual basis, based on Ryan White Part C and federal guidelines. To apply for this benefit, please fill out this application and release of information and return it to:

Sioux Falls Health Department
Ryan White Part C Program
521 North Main Avenue, Suite 100
Sioux Falls, SD 57104

Patient Name: _____
(First) (MI) (Last)

Date of Birth: _____/_____/_____ Phone Number: _____

Address: _____

_____

Gender: ☐ Male ☐ Female ☐ Transgender ☐ Refuse to report ☐ Unknown

Race: ☐ White ☐ Black ☐ American Indian ☐ Asian ☐ Unknown

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐Unknown

Medical Provider: _____

Gross Income: _____ monthly/annual (circle one)

Number of people in your household: _____

Private Insurance (name of insurance company): _____

Group No. _____ Individual No. _____

Medicaid: ☐ Yes ☐ No Medicaid No. _____

Medicare: ☐ Yes ☐ No Medicare No. _____

I hereby authorize the Ryan White Part C representatives to review my medical record for the purpose of continuous state-of-the-art quality improvement. I understand that my record will not be copied or removed from its original location.

Signed: _____ Date: _____

I certify that the information I have provided to the Ryan White Part C representatives for purposes of the Ryan White Part C Program is accurate and current. I understand that it is my responsibility to provide accurate documentation and information as requested.

I understand that the Ryan White Part C funds must be a payer of last resort. If I have insurance or any other payer source, this must be billed first.

_____
(Signature) (Date)

_____
(Witness) (Date)