RYAN WHITE PART B
PROGRAM APPLICATION

Please Print Information Legibly Below
***Required Field**

Demographics

***First Name:**	***SSN:**
Middle Name:	
***Last Name:**	***Date of Birth:**
Name Suffix: ○Sr. ○Jr. ○II ○III ○IV	
Nickname:	

***Sex at Birth:** ○Male ○Female

***Current Gender:** ○Male ○Female

***Marital Status:** ○Single ○Married ○Divorced ○Legally Separated ○Partnered ○Widowed

Preferred Language:

***Ethnicity:** (Check all that apply)

☐ Non-Hispanic/Latino(a)

☐Hispanic/Latino(a) *(*If selected, specify*):
☐Cuban ☐Mexican, Mexican American/Chicano(a)
☐Other Hispanic/Latino(a) or Spanish origin) ☐Puerto Rican

Race (Select all that apply):*

☐White

☐Black or African American

☐Asian *(*If selected, specify*):
☐Asian Indian ☐Chinese
☐Filipino ☐Japanese
☐Korean ☐Other Asian
☐Vietnamese

☐Native Hawaiian or Other Pacific Islander
*(*If selected, specify*):
☐ Guamanian or Chamorro ☐Native Hawaiian
☐ Other Pacific Islander ☐Samoan

☐ American Indian or Alaska Native

Referred by: ○Self ○Other ○No Referral

Name and phone # of person (if any) who helped you complete this form:

Client Initials ☐☐

Contact Information

Please Print Information Legibly Below ***Required Field**

Is Client Homeless/Transient ○Yes ○No

Residential Address:

Address 1:	**State:**
Address 2:	**Zip:**
City:	**County:**

Mailing Address:

***Is Mailing Address the same as Residential Address?** ○**Yes** ○**No** *(Please enter Mailing Address below if different)*:

Address 1:	**State:**
Address 2:	**Zip:**
City:	**County:**

The address you listed above is where ODH will send mail to you.

***Is it OK to mail to this address?** ○**Yes** ○**No**

Medication Shipping Address *(Cannot be Case Management Agency Address.)*

***Where is your medication to be sent? NOTE:** (Medication is mailed from a third-party pharmacy, not ODH.)

○**Residential Address** ○**Mailing Address** ○**Not Applicable - not on HIV Medication** ○**Medication Address**

Address 1:	**State:**
Address 2:	**Zip:**
City:	**County:**

Telephones:

Cell:	**Is it OK to leave message?**	○Yes ○No
Home:	**Is it OK to leave message?**	○Yes ○No
Work:	**Is it OK to leave message?**	○Yes ○No
Other:	**Is it OK to leave message?**	○Yes ○No

Email Address: _____ **Do you authorize ODH to send confidential, private health information to this email address?** ○Yes ○No

Client Initials ☐☐

Contact Information (continued)

Please Print Information Legibly Below

***Ohio Residency Verification Documents Attached** *(Check all that apply)*:

- ☐ Current Driver's License
- ☐ Current State of Ohio ID
- ☐ Current Lease/Letter from Landlord
- ☐ Utility Bill within 90 days
- ☐ Benefit/Award Letter with Ohio address
- ☐ Other *(If Other, specify)*:

Emergency Contact Information ***(This must be someone we can contact who knows your HIV status)*:**

Client Has Emergency Contact? ○ Yes ○ No (*If Yes, enter name below.*)

*First Name:

*Last Name:

Emergency Contact Relationship (*Select only one*):

- ○ Brother
- ○ Child
- ○ Father
- ○ Friend
- ○ Mother
- ○ Other Family Member
- ○ Other Non-Family Member
- ○ Partner
- ○ Roommate
- ○ Sister
- ○ Spouse

*Emergency Contact Phone Number:

Case Manager

Agency Name:

Agency Telephone Number:

Agency Fax:

Case Manager:

Case Manager Telephone Number:

Extension:

Case Manager Email:

All fields marked with an asterisk (*) are mandatory/required fields.

CLIENT FINANCIAL INFORMATION

*Client Employment Status *(Check all that apply)*:	
☐ Fulltime (40 or more hours per week)	☐ Part-time
☐ Self Employed	☐ Disability
☐ Retired	☐ Unemployed
☐ Unknown	

Household Size:	
Client Income Verification Documents (Select and attach all that apply)*	
☐ Benefits/Award Letter	☐ Pay Stub
☐ Verification of Income Statement	☐ Tax Transcript (only required for Self-Employed)
☐ Other (specify)*	

NON MAGI INCOME SOURCES	CLIENT AMOUNT	PAY FREQUENCY
Supplemental Income from Social Security (SSI)	$	Monthly
Child Support Received, Workers' Comp, Monetary Gifts	$	☐ Daily ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly ☐ One time only
MAGI INCOME SOURCES	**CLIENT AMOUNT**	**PAY FREQUENCY**
Wages/Salary/Tips	$	One time only
Disability Income from Social Security (SSDI)	$	One time only
Retirement Income from Social Security (SSA)	$	One time only
Other Income Type:		**FREQUENCY**
☐ Alimony/Spousal Support Rcvd	$	One time only
☐ Business Income/Loss	$	One time only
☐ Capital Gain/Loss	$	One time only
☐ Farm Income/Loss	$	One time only
☐ IRA Distribution Taxable Amount	$	One time only
☐ Ordinary Dividends	$	One time only
☐ Other Gains/Losses	$	One time only
☐ Other Income (Jury Duty Pay, Gambling Winnings)	$	One time only
☐ Other Pensions, Retirements, Disability	$	One time only
☐ Rental Real Estate	$	One time only
☐ Tax Exempt Interest	$	One time only
☐ Taxable Interest	$	One time only
☐ Unemployment Income	$	One time only
☐ Self-Employed Income	$	One time only
TOTAL INCOME (AGI)	$	Line A
***ADJUSTMENTS SUBTRACTED FROM INCOME**		**FREQUENCY**
☐ Business Expenses	$	One time only
☐ Tuition and Fees	$	One time only
☐ Alimony Paid	$	One time only
☐ Deductible Part Self-Employment Tax	$	One time only
☐ Domestic Production Activities	$	One time only
☐ Educator Expenses	$	One time only
☐ Health Savings Account	$	One time only
☐ IRA Deduction	$	One time only
☐ Moving Expenses	$	One time only
☐ Penalty on Early Withdrawal/Savings	$	One time only
☐ Self-Employed Health Insurance Deduct.	$	One time only
☐ Student Loan Interest Deduction	$	One time only
TOTAL ADJUSTMENTS	$	Line B
TOTAL MAGI	$	Line A minus Line B

All fields marked with an asterisk (*) are mandatory/required fields.

HOUSEHOLD (HH) MEMBER INFORMATION

	Household Member 1	Household Member 2	Household Member 3
First Name*			
Middle Name			
Last Name*			
Relationship to Client*			
Date of Birth*			
Is this person*	○ Living at Same Address ○ Living at Different Address ○ No longer HH Member	○ Living at Same Address ○ Living at Different Address ○ No longer HH Member	○ Living at Same Address ○ Living at Different Address ○ No longer HH Member
Is this person covered by client's insurance?*	○ YES ○ NO	○ YES ○ NO	○ YES ○ NO
Is this person also a client?*	○ YES ○ NO	○ YES ○ NO	○ YES ○ NO
If Yes, What RW ID?*			
Is this HH member included in HH Count? *	○ YES ○ NO	○ YES ○ NO	○ YES ○ NO
Does this HH Member Receive any type of Income? *	○ YES ○ NO	○ YES ○ NO	○ YES ○ NO
Is this HH Member included in Income Calculation? *	○ YES ○ NO	○ YES ○ NO	○ YES ○ NO

This page and the next will allow you to identify up to 6 additional members of the client's household. If the client's household is larger than that, please feel free to copy these pages to collect information on all members of the client's household.

For each household member <u>with income</u> that contributes to the overall household income calculation, please complete the Household Member Income Form on page 8 of this application (feel free to make a copy of that form for each household member with contributing income).

HOUSEHOLD (HH) MEMBER INFORMATION

	Household Member 4	Household Member 5	Household Member 6
First Name*			
Middle Name			
Last Name*			
Relationship to Client*			
Date of Birth*			
Is this person*	○ Living at Same Address ○ Living at Different Address ○ No longer HH Member	○ Living at Same Address ○ Living at Different Address ○ No longer HH Member	○ Living at Same Address ○ Living at Different Address ○ No longer HH Member
Is this person covered by client's insurance?*	○ YES ○ NO	○ YES ○ NO	○ YES ○ NO
Is this person also a client?*	○ YES ○ NO	○ YES ○ NO	○ YES ○ NO
If Yes, What RW ID?*			
Is this HH member included in HH Count? *	○ YES ○ NO	○ YES ○ NO	○ YES ○ NO
Does this HH Member Receive any type of Income? *	○ YES ○ NO	○ YES ○ NO	○ YES ○ NO
Is this HH Member included in Income Calculation? *	○ YES ○ NO	○ YES ○ NO	○ YES ○ NO

For each household member <u>with income</u> that contributes to the overall household income calculation, please complete the Household Member Income Form on page 8 of this application (feel free to make a copy of that form for each household member with contributing income).

Client Initials ☐☐

HOUSEHOLD MEMBER INCOME FORM **Household Member Name:** _____

NON MAGI INCOME SOURCES	AMOUNT	PAY FREQUENCY
Supplemental Income from Social Security (SSI)	$	Monthly
Child Support Received, Workers' Comp, Monetary Gifts	$	☐ Daily ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly ☐ One time only

MAGI INCOME SOURCES	AMOUNT	PAY FREQUENCY
Wages/Salary/Tips	$	One time only
Disability Income from Social Security (SSDI)	$	One time only
Retirement Income from Social Security (SSA)	$	One time only
Other Income Type:		**FREQUENCY**
☐ Alimony/Spousal Support Rcvd	$	One time only
☐ Business Income/Loss	$	One time only
☐ Capital Gain/Loss	$	One time only
☐ Farm Income/Loss	$	One time only
☐ IRA Distribution Taxable Amount	$	One time only
☐ Ordinary Dividends	$	One time only
☐ Other Gains/Losses	$	One time only
☐ Other Income (Jury Duty Pay, Gambling Winnings)	$	One time only
☐ Other Pensions, Retirements, Disability	$	One time only
☐ Rental Real Estate	$	One time only
☐ Tax Exempt Interest	$	One time only
☐ Taxable Interest	$	One time only
☐ Unemployment Income	$	One time only
☐ Self-Employed Income	$	One time only
TOTAL INCOME (AGI)	$	Line A

*ADJUSTMENTS SUBTRACTED FROM INCOME		FREQUENCY
☐ Business Expenses	$	One time only
☐ Tuition and Fees	$	One time only
☐ Alimony Paid	$	One time only
☐ Deductible Part Self-Employment Tax	$	One time only
☐ Domestic Production Activities	$	One time only
☐ Educator Expenses	$	One time only
☐ Health Savings Account	$	One time only
☐ IRA Deduction	$	One time only
☐ Moving Expenses	$	One time only
☐ Penalty on Early Withdrawal/Savings	$	One time only
☐ Self-Employed Health Insurance Deduct.	$	One time only
☐ Student Loan Interest Deduction	$	One time only
TOTAL ADJUSTMENTS	$	Line B
TOTAL MAGI		Line A minus Line B

Client Initials ☐☐

Proof of income must be provided for ALL members of the household who have income.

Household Member 1 Income Verification Documents (Select and attach all that apply)*	
☐ Benefits/Award Letter	☐ Pay Stub
☐ Verification of Income Statement	☐ Tax Transcript (only required for Self-Employed)
☐ Other (specify)*	

Household Member 2 Income Verification Documents (Select and attach all that apply)*	
☐ Benefits/Award Letter	☐ Pay Stub
☐ Verification of Income Statement	☐ Tax Transcript (only required for Self-Employed)
☐ Other (specify)*	

Household Member 3 Income Verification Documents (Select and attach all that apply)*	
☐ Benefits/Award Letter	☐ Pay Stub
☐ Verification of Income Statement	☐ Tax Transcript (only required for Self-Employed)
☐ Other (specify)*	

Household Member 4 Income Verification Documents (Select and attach all that apply)*	
☐ Benefits/Award Letter	☐ Pay Stub
☐ Verification of Income Statement	☐ Tax Transcript (only required for Self-Employed)
☐ Other (specify)*	

Household Member 5 Income Verification Documents (Select and attach all that apply)*	
☐ Benefits/Award Letter	☐ Pay Stub
☐ Verification of Income Statement	☐ Tax Transcript (only required for Self-Employed)
☐ Other (specify)*	

Household Member 6 Income Verification Documents (Select and attach all that apply)*	
☐ Benefits/Award Letter	☐ Pay Stub
☐ Verification of Income Statement	☐ Tax Transcript (only required for Self-Employed)
☐ Other (specify)*	

Client Initials ☐☐

Insurance Information

Client has Private Health Insurance?*		○ Yes	○ No
☐	Private Insurance--Employer	☐	COBRA Policy (*if yes, please attach COBRA election form*)
☐	Private Insurance--Individual		COBRA Start Date COBRA End Date
☐	Marketplace Plan	☐	Other (Specify):
Client has Medicare?*		○ Yes	○ No
Medicare Part A/B (Part B does not pay for these)*		○ Yes	○ No
Medicare Part C (Advantage Plan)*		○ Yes	○ No
Medicare Part D*		○ Yes	○ No
Client has Medicaid?*		○ Yes	○ No
If Yes, date Medicaid Determination Letter received:			
Medicaid Case Number:			
Medicaid Billing Number:			
Client had Medicaid Managed Care?		○ Yes	○ No
Medicaid Managed Care Provider Name			
Client has Applied for Medicaid?*		○ Yes	○ No
Date client applied for Medicaid:			
Status of Medicaid Application:		○ Denied	○ Pending
Comments			
Client has Veteran's Benefits?*		○ Yes	○ No
Client has Other Coverage		○ Yes	○ No
If yes, specify:			
Client Requests Formulary Assistance?*		○ Yes	○ No
Client needs Assistance with Meds not Covered by Insurance?*		○ Yes	○ No
List the Medications Not Covered by Insurance:			

HIPAA Release on file? ○ Yes ○ No

*If Yes, date signed:

Premiums

Does Client want assistance with premium payments?* ○ **Yes** ○ **No**

Policy Holder Information		
Is the client the policy holder? ○ Yes *(Skip to Premium Payment information)* ○ No		
*If No, Enter Policy holder's name:		
Is Policy Holder a Ryan White client? ○ Yes ○ No		
If Yes, enter Policy Holder's date of birth:	Last four digits of Policy Holder's SSN:	
Relationship of policy holder to Client:		

Premium Payment Information		
Holder's Policy/Member ID:	**Health Plan Number:**	
Group Name:	**Group Number:**	
Customer Service Telephone:	**Number of People Covered by Policy?**	
Premium Amount		**Disbursement Note:**
Health:	$	
Dental:	$	
Other:	$	
Specify Other		
Total Monthly Insurance Premium Cost:	$	**Check Memo Line**: *(Please fill in as required by the insurance company. For example: Name, MemberId, DOB)*
ADAP Payment Frequency	○ Monthly	
	○ Quarterly	
	○ 6 Months	
	○ Yearly	
Employer Providing Coverage:		
Contact Person:		
Telephone:		

Client Initials ☐☐

Insurance Company Information*

*Insurance Company Name:	TIN:

Payment Address:

Attn:		Telephone:
Payee Name:		
Address 1:		Fax:
Address 2:		
City:		Email:
State:	Zip:	

Rx Copayments

***Does Client want assistance with prescription (Rx) copayments?** ○ **Yes** ○ **No**

Medication Copayment Information:

Rx ID:	Rx Bin:
Rx Group:	Rx PCN:
Contact Person:	Telephone:

	*Insurance Verification Documents Attached:
☐	Legible copy of front of Insurance Card
☐	Legible copy of back of Insurance Card
☐	Explanation of Benefits (EOB) from Insurance Company
☐	Explanation of Payment (EOP) from Insurance Company
	***Rx Copayment Verification Documents Attached:**
☐	Legible copy of front of Rx Card
☐	Legible copy of back of Rx Card

Client Initials ☐☐

Medical Information

Client Self-Report

*Do you have a healthcare provider for HIV / AIDS care? ○ Yes ○ No If Yes, enter provider's information below:				
Provider First Name:	**Address 1**:			
	Address 2:			
Provider Last Name:	**City**:			
	State:		**Zip**:	
Telephone:				

*__Year of first positive HIV test:__

Lowest CD4+ Count Ever (NADIR):

HIV Status: ○ HIV-Positive, Not AIDS ○ HIV-Positive, AIDS Status Unknown ○ CDC-defined AIDS

HIV Exposure Category:

- ○ MSM (Male having sex with another male)
- ○ IDU (Injection drug use)
- ○ Hemophilia/coagulation disorder
- ○ Heterosexual contact
- ○ Recipient of blood transfusion/blood components (other than clotting factor)
- ○ Perinatal transmission (from mother to baby)
- ○ Other (If yes, you must specify):
- ○ Unknown

*Is your doctor prescribing Antiretroviral Therapy (ART)? ○ Yes ○ No

*Have you been diagnosed with Hepatitis B? ○ Yes ○ No

*Have you been diagnosed with Hepatitis C? ○ Yes ○ No

*Are you pregnant? ○ Yes ○ No ○ Not Applicable

If Yes, Indicate Due Date:

Client Initials ☐☐

VERIFICATION OF INCOME
FOR ALL APPLICANTS

I, _____ *(print applicant name)* swear or affirm that I currently do not receive income of any type that has not already been reported in my application for the Ohio Ryan White Part B programs including the OHIO HIV Drug Assistance Program (OHDAP). I understand that income includes all money received from work, even that which is not reported for tax purposes. Income also includes, but is not limited to, money received from retirement, investments, unemployment compensation, and disability benefits. I am aware that I must also report any and all income earned by a married spouse (if married) and parents (if a dependent).

I am aware that providing false, incomplete or inaccurate information regarding income or any other aspect of the application may result in my inability to receive further assistance from any and all Ryan White Part B funded programs.

Applicant Signature : _____

Date :

NOTE: This form (Ryan White Part B Verification of Income) is also available as a stand-alone form (HEA 0169).

Document requiring signature on reverse side, this page left intentionally blank.

AUTHORIZATION FOR PROOF AND
RELEASE OF INFORMATION AND HIV/AIDS REPORTING

The number of HIV cases reported in Ohio determines funding for HIV/AIDS services. HIV/AIDS reporting has significant impact on the dollars available to assist individuals. Monies for the Ryan White Part B Programs (e.g., OHDAP, HIPP, medical case management, financial assistance, etc.) are granted to Ohio based upon the reported number of people living with HIV/AIDS in our state.

Ohio law mandates that HIV and AIDS cases be reported to the Ohio Department of Health.

I understand that submitting this application to the Ryan White Part B program at the Ohio Department of Health may generate a confidential HIV/AIDS case report form to comply with Ohio law.

I authorize the Ohio Department of Health to verify all the information stated in my application to receive Ryan White Part B services relative to my medical condition, program eligibility status, financial income and available resources, insurance benefits, and other sources of assistance available to me.

I understand and agree that the Ohio Department of Health will communicate with private and governmental individuals, entities, agencies, organizations, or third-party agents of the Department, as appropriate. Communication will be to determine my current, on-going, or future eligibility, for care coordination and program administration, or to assist me in receiving services through this or other programs. Communication may include, but is not limited to, my emergency contact, my physician or any provider listed on the application, my medical case manager, and my county Department of Job and Family Services office.

I understand that I must inform the Ryan White Part B program if any of the information regarding my eligibility status (e.g., HIV status, Ohio residency status, financial/income status) changes in any way. I understand that providing false, incomplete, or inaccurate information may result in termination or denial of benefits or possible legal action.

By my signature below, I affirm that to the best of my knowledge and belief, the answers and information furnished are complete and correct. I agree to the release of my information to the necessary individuals, entities, organizations, and/or agencies as described above, including to verify the information I have provided. I understand Ohio mandates HIV and AIDS case reporting.

_____ _____

Signature of applicant (or guardian, if applicable) Date of Signature

Signature of applicant or person legally responsible for the applicant (if the applicant is a minor or a disabled dependent) is required. This authorization is good for a period of two (2) years from the date of signature unless revoked by the applicant in writing. Revoking this authorization may prevent the Ohio Department of Health from verifying the applicant's eligibility for program services.

Appeal Procedures

You may appeal to the Director of the Ohio Department of Health (or designee), if:

1) Your application for the Ryan White Part B Program assistance is denied OR
2) Your assistance via the Ryan White Part B program is terminated.

If you believe you have been discriminated against because of race, color, national origin, sex, sexual orientation, age, handicap, religion, or political belief, you have the right to file a complaint with the Ohio Department of Health, 246 N. High Street, Columbus, OH 43266-0118; or with the Secretary of the Department of Health and Human Services, Washington, DC 20201.

NOTE: This form (Ryan White Part B Authorization for Proof and Release of Information) is also available as a stand-alone form (HEA 0171).

Document requiring signature on reverse side, this page left intentionally blank.

INDIVIDUAL AUTHORIZATION FORM (HIPAA RELEASE)

INDIVIDUAL'S INFORMATION

Include information about the individual whose information will be released.

Name

DOB:

SSN

Address:

Member ID (on Insurance Card):

RELEASE/RECEIVE INFORMATION

In the box below, insert the person/organization allowed to release the information.

The following company is allowed to release the information requested (insert name of insurance company/employer if company is self-insured):

The information can be provided to: Health Insurance Premium Payment (HIPP) Program
Ohio Department of Health, 246 N. High Street, Columbus, OH 43215
1-800-777-4775

WHAT INFORMATION IS BEING RELEASED

The HIPP program of the Ohio Department of Health is the third-party payer of my insurance premium. As a result, I give my permission for release of the following information:

- Premium Information
- Payment History
- Policy Information
- Prescription Drug Benefit Information
- Correct address information to ensure prompt payment

PURPOSE OF RELEASE

The purpose of this release is to ensure prompt payment of my insurance premiums. As such, any communication from representatives of the HIPP program at the Ohio Department of Health will be in the interest of pursuing this effort.

EXPIRATION DATE

If not previously revoked in writing, this authorization will terminate three months from the date my coverage ends.

SIGNATURE

A copy of this authorization is available to me upon request and will serve as the original. I understand that if this information is to be received by individuals or organizations that are not health care providers, health care clearinghouses or health plans covered by federal privacy regulations, my information described above may be re-disclosed by the recipient unless protected by other state or federal law. This authorization is subject to revocation at any time upon written notice to the person/company specified above except to the extent that the person/company has already taken action on the disclosure prior to the revocation. I also understand that I may refuse to sign this authorization; however, my refusal to sign will prevent HIPP from providing services to me.

_____ Date:

Signature of insured adult, parent/guardian of minor insured

_____ Date:

Signature of legal representative of insured (if applicable)

If a legal representative of insured signs on behalf of the individual, a copy of the legal representative's authority must be attached to this form.

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION.

NOTE: This form (HIPAA Release) is also available as a stand-alone form (HEA 0170).

Document requiring signature on reverse side, this page left intentionally blank.

Attachments Checklist

RESIDENCY VERIFICATION DOCUMENTS

Please include at least one of the following:

- Current OH Driver's License
- Utility Bill within the last 90 days
- Current State of Ohio ID
- Benefit/Award Letter with OH address
- Lease/Letter from Landlord
- Addressed Postmarked Envelope from official source *(i.e. IRS, SSA, Medicare, Medicaid, ODJFS)*
- Other

FINANCIAL VERIFICATION DOCUMENTS

All applications must include:

- Signed Verification of Income Statement

In addition, please include at least one of the following:

- Benefit/Award Letter
- Pay Stubs (4 consecutive weeks within 45 days of applying for services)
- Other

INSURANCE VERIFICATION DOCUMENTS

- Insurance Card (front and back)
- Prescription Card (front and back)
- Explanation of Benefits (EOB) Notice
- Explanation of Payments (EOP) Notice
- HIPAA Release
- Other

MEDICAL VERIFICATION DOCUMENTS

Please note that medical verification documents are required to establish that an individual is HIV+ and, thus, eligible for our services. At this time, it is not necessary to submit medical verification documents with each application unless there are some additional questions regarding client health.

- Lab Results, including any of the following:
  - CD4+ cell count
  - HIV RNA (viral load)
  - Positive HIV Serology Results
  - Genotype Results
  - Tropism Test
  - Abacavir HLA Antibody Test
  - Western Blot
  - Other (e.g., a hospital discharge letter specifying condition)

RELEASES OF INFORMATION

- Program Release