Ryan White Request for Client Assistance
Funds Fiscal Year 2017 - 2018

HEALTH INSURANCE PREMIUM AND COST SHARING/ EFA MEDICATIONS

Client URN: _____

Case Manager: _____ **Email:** _____

Agency: _____

Address: _____

Phone: _____ **Fax:** _____

Request: ◯ **Health Insurance Premium & Cost Sharing**
◯ **EFA Medications**

Reason for Request (Please be specific. "No other funding available" is not acceptable):

Identify all other funding sources you have applied to in order to get this request paid, and note amount(s) received. That amount will be deducted from the requested amount, unless otherwise indicated.

☐ **Medicaid/Husky** _____ ☐ **ACA** _____ ☐ **CADAP** _____ ☐ **CIPA** _____

☐ **Medicare** _____ ☐ **Other (e.g. VA)** _____

Amount of Request: _____ **Check Payable to:** _____

Mail payment to:

Case Manager Signature: _____ **Date:** _____

Case Manager Supervisor Signature: _____ **Date:** _____

FOR OFFICE USE ONLY	**Funds Used:** ☐ **RWA** ☐ **RWB**