FAX

TO: AIDS Connecticut Client Assistance, Fax # 860-761-6711

FROM:_____ Email: _____

DATE:_____ PAGES:_____ (including cover)

RE: **ACT CAF Request**

Required Checklist:

In CW Attached

- ❑ Request for Service Form
  - ❑ Medical Fee-for-Service
  - ❑ Health Insurance Premium & Cost Sharing Assistance
  - ❑ Medication Assistance
  - ❑ Transportation, including Transportation Arrangement Form
  - ❑ Food Voucher
  - ❑ Utilities

❑ ❑ Signature of Requesting Case Manager

❑ ❑ Signature of Supervisor

❑ ❑ Referral (and grant Clinical and Service Sharing in CAREWare, if applicable)

❑ ❑ Ryan White Intake Form OR CAREWare Demographic Report

❑ ❑ Up-to-date Annual Review

❑ ❑ Ryan White Eligibility Worksheet and Income Verification

❑ ❑ Release of Information to AIDS Connecticut *(external agencies ONLY)*

❑ ❑ Signed ACT Policies and Procedures

❑ ❑ Signed Consent Agreement Statement

❑ ❑ Signed ACT CAREWare Consent for Sharing

❑ ❑ Signed CAREWare Consent for Sharing *(external agencies ONLY)*

❑ ❑ CD4/VL within last 6 months (or doctor's note stating not medically necessary)

❑ ❑ Supporting documentation (e.g., detailed invoice, itemized bill)

****For housing requests, please use the HAF Fax Checklist**