**Ryan White Request for Client Assistance Funds**
**Fiscal Year 2018 - 2019**

## HEALTH INSURANCE PREMIUM AND COST SHARING/EFA MEDICATIONS

**Client URN:** _____

**Case Manager:** _____ **Email:** _____

**Agency:** _____

**Address:** _____

**Phone:** _____ **Fax:** _____

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**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)** _____

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

**Mail payment to:**

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

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

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