INDIANA ALL PARTS: NOTICE OF CHANGE FORM

This form is to be used to document changes in:

- Client eligibility (i.e., residency, insurance, income)
- Demographic information (i.e., name, gender)
- Updates or corrections (i.e., NMCM care site, social security number, date of birth)

APPLICANT INFORMATION *(required)*			
Legal First Name		Date of birth (MM/DD/YYYY)	
Legal Last Name			

☐ **CHANGE IN NAME**	
Name currently in RWISE	**New name to be entered in RWISE**

☐ **CHANGE IN GENDER**	
Self-reported gender currently in RWISE	**New self-reported gender to be entered in RWISE**
☐ Male ☐ Transgender – male to female	☐ Male ☐ Transgender – male to female
☐ Female ☐ Transgender – female to male	☐ Female ☐ Transgender – female to male
☐ Unknown ☐ Transgender – other	☐ Unknown ☐ Transgender – other

☐ **CHANGE IN ADDRESS & PHONE**	
Current home address (address at where the individual sleeps most often) **Note:** PO Box is not acceptable to establish residency.	Street Address including apartment number: City: State: ZIP code:
Can the applicant receive hard copy mail at this address? ☐ Yes ☐ No	Are the home address and mailing address the same? ☐ Yes ☐ No
Current mailing address (if different than home address) **Note:** PO Box is acceptable for mailing purposes.	PO Box/Street Address: City: State: ZIP code:
Preferred method of contact (choose all that apply)	☐ Phone: Can a message be left? ☐ Yes ☐ No ☐ Email: ☐ Other:
Did the applicant move outside the TGA?	☐ Yes ☐ No
Did the applicant move inside the TGA?	☐ Yes ☐ No

☐ **CHANGE IN HOUSEHOLD SIZE OR INCOME**		
Household size	**Total Monthly Gross Income**	**Total Annual Gross Income**

☐ **CHANGE IN PUBLIC OR PRIVATE INSURANCE COVERAGE**		
☐ Medicaid ☐ Medicare ☐ Private – employer:	☐ Private – individual: ☐ FFM plan: ☐ Other:	☐ Veterans Affairs ☐ Indian Health Service ☐ No insurance

☐ **VOLUNTARY WITHDRAWAL FROM PROGRAM**	
Date (MM/DD/YYYY)	
Client requests to withdrawal from: ☐ IDOH HIV Services Program support services ☐ IDOH HIV Services Program medication access (i.e, ADAP/EIP, HIAP, HIP Basic, HIP Plus, MDAP)	 ☐ MCPHD Part A services ☐ MCPHD Part C services ☐ MCPHD MAI services

☐ **CHANGE IN VITAL STATUS**	
Deceased date (MM/DD/YYYY)	**Informant**

ATTESTATION ***(required)***

Please mark all services that this update needs to be sent to:

☐ RWHAP Part A ☐ RWHAP Part B ☐ RWHAP ADAP
☐ RWHAP Part C ☐ RWHAP Part A MAI

I hereby certify that the information provided on this form is accurate to the best of my knowledge. I have informed the client that information is being sent to IDOH.

NMCM signature:______________________________________ Date (MM/DD/YYYY):