



TGNB (TRANSGENDER and NONBINARY) / HIV/AIDS / Homelessness ATTESTATION FORM

This form may be completed by a Physician, Nurse Practitioner, or Physician Assistant who can attest to the status of a new member. Per NY State Medicaid regulations for Special Needs Plans, Amida Care members must be verified within their first 90 days as transgender, unhoused, or living with HIV. Timely completion of this attestation is crucial for this member’s continued coverage with Amida Care. Attestation forms can also be found on the Amida Care website.

Applicant Information

Name on Medicaid Card: _____

Chosen Name (if different): _____

Gender Identity: _____ Pronoun(s): _____

DOB: _____ Medicaid #: _____

Provider Attestation – (fill in what is applicable to the member)

TGNB Attestation

1. Please indicate type of qualifying provider completing this form:

- Physician Nurse Practitioner Physician Assistant

2. I attest that _____ is transgender or non- binary and has
(applicant name)
undergone appropriate clinical treatment for a person diagnosed with gender dysphoria.

3. In order to provide linkage to medically appropriate preventative health services we ask that you provide us with the member’s sex assigned at birth, as indicated below:

- Male Female Intersex Other _____

HIV/AIDS

1. Attach laboratory test(s) with undetectable VL that have clear date(s).

2. List current ARV’s you, the treating PCP, have prescribed:

3. How long patient has been with you, the treating PCP? Specify dates.

from _____ to _____.

**Email completed form to:
AmidaCare**

EligibilityVerification@amidacareny.org

Or Fax

Attention: HealthServices

Fax: 646-786-1802

Tel: 646-757-7000



4. How was HIV status determined by you, the treating PCP, without confirmatory laboratory data? Please specify.

NOTE: Please check box if patient is HIV negative.

Homelessness

I attest that _____

(Member Name)

lacks a fixed, regular, and adequate nighttime residence and is homeless:

1. they have a primary nighttime residence that is:
a public or private place not meant for human habitation.

2. they live in
a publicly or privately operated shelter designated to provide temporary living arrangements.

Name of Shelter; Type: _____

Address of Shelter _____

3. they are exiting an institution: *(Specify place)*
where they have resided for 90-days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering the institution.

Name of Institution _____

Address of Institution _____

Attesting Provider/Nurse Practitioner/ Physician Assistant Signature

Completed by: _____

Signature: _____

Site Name: _____

NPI Number: _____

Date: _____

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