60 calendar days of the date the Department denied the petition for payment.

(b) *Request for reconsideration*. The request for reconsideration must state the reasons why the petitioner is seeking reconsideration. However, the request for reconsideration may not include any additional documentation that was not included in the completed petition.

(c) *Review process*. When the Deputy Associate Administrator for Health Professions receives a request for reconsideration, he will convene a panel of three individuals, who are independent of the Ricky Ray Program Office, to review the initial determination and make a recommendation regarding payment. The Deputy Associate Administrator for Health Professions will review the panel's recommendation and then determine whether the petitioner is eligible for payment under the Act. The Deputy Associate Administrator for Health Professions' determination will constitute the Department's final action on the request for reconsideration. If the determination is that the petitioner is eligible for payment, the petitioner will receive payment as described in § 130.3. If the determination is that the petitioner is not eligible for payment, the Deputy Associate Administrator for Health Professions will inform the petitioner in writing of the reasons for this determination.

Subpart F—Attorney Fees

§ 130.50 Limitation on agent and attorney fees.

As provided by section 107 of the Act:

(a) Notwithstanding any contract, the representative of an individual may not receive, for services rendered in connection with the petition of an individual under this Act, more than 5 percent of a payment made under this Act (*i.e.*, $5,000) on the petition.

(b) Any such representative who violates this section is subject to a fine of not more than $50,000.

APPENDIX A

Definition of HIV infection or HIV for purposes of §130.2(i)(1):

(1) Except as provided in section (2) below, a diagnosis of HIV infection under 130.2(i)(1) may be made on the basis of a diagnosis of one or more of the following opportunistic diseases:

- Candidiasis of bronchi, trachea, or lungs
- Candidiasis, esophageal
- Cervical cancer, invasive
- Chronic lymphoid interstitial pneumonitis (in a child under 13 years of age)
- Coccidioidomycosis, disseminated or extrapulmonary
- Cryptococcosis, extrapulmonary
- Cryptosporidiosis, chronic intestinal (greater than 1 month's duration)
- Cytomegalovirus disease (other than liver, spleen, or nodes)
- Cytomegalovirus retinitis (with loss of vision)
- Encephalopathy, HIV-related
- Herpes simplex: chronic ulcer(s) (greater than 1 month's duration); or bronchitis, pneumonitis, or esophagitis
- Histoplasmosis, disseminated or extrapulmonary
- Isosporiasis, chronic intestinal (greater than 1 month's duration)
- Kaposi's sarcoma
- Lymphoma, Burkitt's (or equivalent term)
- Lymphoma, immunoblastic (or equivalent term)
- Lymphoma, non-Hodgkin's
- Lymphoma, primary, or brain
- Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary
- Mycobacterium tuberculosis, any site (pulmonary or extrapulmonary)
- Mycobacterium, other species or unidentified species, disseminated or extrapulmonary
- Pneumocystis carinii pneumonia
- Pneumonia, recurrent
- Progressive multifocal leukoencephalopathy
- Salmonella septicemia, recurrent
- Toxoplasmosis of brain
- Wasting syndrome due to HIV

(2) The opportunistic diseases listed in section (1) above may be used to diagnose an HIV infection, unless: the opportunistic diseases are diagnosed based on a known immunodeficiency disease other than HIV infection, including, but not limited to: (i) Primary immunodeficiency diseases - severe combined immunodeficiency, DiGeorge syndrome, Wiskott-Aldrich syndrome, ataxia-telangiectasia, graft versus host disease, neutropenia, neutrophil function abnormality, agammaglobulinemia, or hypogammaglobulinemia with raised IgM; and (ii) Secondary immunodeficiency associated with immunosuppressive therapy, lymphoreticular malignancy (if less than 3 months after the diagnosis of the aforementioned opportunistic disease), or starvation.

These excerpts were taken from:

Current Trends Update: Acquired Immunodeficiency Syndrome (AIDS) - United States, MMWR 32(52); 688-91, January 6, 1984.

Current Trends Revision of the Case Definition of Acquired Immunodeficiency Syndrome for National Reporting - United States, MMWR 34(25); 373-75, June 28, 1985.

1993 Revised Classification System for HIV Infection and Expanded Surveillance Case Definition for AIDS Among Adolescents and Adults, MMWR 41(RR-17), December 18, 1992.

For further information, please consult these documents.

APPENDIX B TO PART 130—CONFIDENTIAL PHYSICIAN OR NURSE PRACTITIONER AFFIDAVIT

OMB No. 0915-0244
Expiration date: 02-14-2001

RICKY RAY HEMOPHILIA RELIEF FUND
CONFIDENTIAL PHYSICIAN OR NURSE PRACTITIONER AFFIDAVIT

The U.S. Congress enacted the Ricky Ray Hemophilia Relief Fund Act in 1998 to make compassionate payments of $100,000 to certain individuals with blood-clotting disorders, such as hemophilia, who were treated with antihemophilic factor between July 1, 1982, and December 31, 1987, and who contracted HIV(referred to in Section A below). Certain spouses, former spouses and children (referred to in Section B below) who contracted HIV from these individuals may also be eligible for compassionate payments. Specified survivors of these individuals may also receive payments.

This affidavit regarding medical documentation is to be completed and signed by a physician or nurse practitioner in lieu of medical records or test results. Although you may be asked to provide additional information, complete only those portions of this affidavit that you can answer based on your personal knowledge or a review of medical records.

PRIVACY ACT STATEMENT

Section 103 of Public Law 105-369 and the Debt Collection Improvement Act of 1996 authorize collection of this information. It will be used to determine your eligibility to receive payments. This information will be disclosed to the Department of Health and Human Services and its consultants; and Federal, State or local law enforcement agencies if the Government becomes aware of a possible violation of civil or criminal law. Furnishing the information on this form, including the Social Security Number, is voluntary, but failure to do so may delay or prevent the receipt of a payment. The information collected will be maintained confidentially pursuant to the Privacy Act.

CHECK APPLICABLE BOXES AND PROVIDE INFORMATION AS REQUESTED.

I am a physician or a nurse practitioner. I have been requested by an individual to complete this affidavit and to provide information that I understand will be kept strictly confidential and be used solely to determine eligibility for a compassionate payment under the Ricky Ray Hemophilia Relief Fund Program.

SECTION A. INFORMATION ON INDIVIDUAL WITH BLOOD CLOTTING DISORDER AND HIV

He or she is a person with blood-clotting disorder who has/had HIV and was treated with antihemophilic factor at any time between July 1, 1982, and December 31, 1987.

Name of Individual: _____

Note: the information requested in the following three statements is required for all individuals described in Section A.

[ ] He/she has/had the following blood-clotting disorder:

[ ] He/she received an antihemophilic factor between July 1, 1982, and December 31, 1987.

[ ] He/she was diagnosed as having HIV.

SECTION B. INFORMATION ON ELIGIBLE INDIVIDUAL WITH HIV IF DIFFERENT FROM SECTION A

This section pertains to other individuals who may be eligible for payment under the Program because of their familial relationship to the person described in Section A.

Name of Individual: _____

[ ] He/she was diagnosed as having HIV. **(Note: this information is required for all individuals in Section B).**

(Section B continued, next page)

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RICKY RAY HEMOPHILIA RELIEF FUND – AFFIDAVIT

[ ] There is reasonable certainty that this individual contracted HIV from the individual identified in Section A. "Reasonable certainty" is defined as having no knowledge based on medical records or other documents that the individual contracted HIV from a source other than the individual identified in Section A. **(Note: This information is required only for an individual filing a petition as the former spouse of the individual described in Section A).**

[ ] This individual acquired HIV through perinatal transmission (transmission of HIV infection from mother to child that occurs during pregnancy, delivery, or breast feeding) from _____ _____. **(Note: This information is required only for an individual filing a petition because he/she acquired HIV through perinatal transmission from the individual in Section A or that individual's current or former spouse).**

SECTION C. SIGNATURE AND SWORN STATEMENT OF PHYSICIAN OR NURSE PRACTITIONER

I swear or affirm under penalty of perjury that the answers I have given to the medical questions listed above in this affidavit are true and correct to the best of my knowledge, information, and belief. (18 U.S.C. § 1621)

Signature: _____ Date: _____

Name (typed or printed legibly): _____

License Number and State Where Licensed: _____

Full Address (number and street): _____

City, State, and Zip Code: _____

Phone: _____

Refer to the definitions for several medical terms in the Rule, 42 CFR Part 130: antihemophilic factor §130.2(b), blood-clotting disorder §130.2(c), hemophilia §130.2(h), HIV infection or HIV §130.2(i), perinatal transmission §130.2(m).

PUBLIC BURDEN STATEMENT

An agency may not conduct or sponsor, and any person is not required to respond to, a collection of information unless it displays a currently valid OMB Control Number. The OMB Control Number for this project is 0915-0244. Public reporting burden for this collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information.

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APPENDIX C TO PART 130—PETITION FORM, PETITION INSTRUCTIONS, AND DOCUMENTATION CHECKLIST

OMB No. 0915-0244
Expiration date: 02-14-2001

RICKY RAY HEMOPHILIA RELIEF FUND
PETITION

This petition is to be used by all parties who may be eligible for payment under the Ricky Ray Hemophilia Relief Fund Act. Refer to the Ricky Ray Documentation Checklist for the supporting documentation that you must provide with the petition. **The petition and its documentation are subject to audit by the U.S. Department of Health and Human Services' Office of Inspector General.**

PRIVACY ACT STATEMENT

Section 103 of Public Law 105-369 and the Debt Collection Improvement Act of 1996 authorize collection of this information. It will be used to determine your eligibility to receive payments. This information will be disclosed to the Department of Health and Human Services and its consultants; and Federal, State or local law enforcement agencies if the Government becomes aware of a possible violation of civil or criminal law. Furnishing the information on this form, including the Social Security Number, is voluntary, but failure to do so may delay or prevent the receipt of a payment. The information collected will be maintained confidentially pursuant to the Privacy Act.

SECTION A. INDIVIDUAL WITH BLOOD-CLOTTING DISORDER AND HIV
This section is mandatory for all petitioners

Check the instructions for Section A.

Name: _____

Social Security Number: _____ Date of Birth: _____

If no longer living, provide date of death: _____

Complete address information if individual is living

Address: _____

City: _____ State: _____ Zip: _____

Daytime phone: _____

SECTION B. ELIGIBLE PERSON WITH HIV (OTHER THAN INDIVIDUAL IDENTIFIED IN SECTION A)
This section is required for the lawful spouse, former lawful spouse, child and their survivors

Check the instructions for Section B.

Name: _____

Social Security Number: _____ Date of Birth: _____

If no longer living, provide date of death: _____

Complete address information if individual is living

Address: _____

City: _____ State: _____ Zip: _____

Daytime phone: _____

RELATIONSHIP TO INDIVIDUAL IN SECTION A *(check one)*:

[ ] Lawful spouse (husband or wife) with HIV
[ ] Former lawful spouse (husband or wife) with HIV
[ ] Child with HIV (if person in Section A is the mother)
[ ] Child with HIV of the lawful wife with HIV
[ ] Child with HIV of the former lawful wife with HIV

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RICKY RAY HEMOPHILIA RELIEF FUND – PETITION

SECTION C. SURVIVOR OF ELIGIBLE PERSON WITH HIV
This section is required of all survivors

Check the instructions for Section C.

Name: _____

Social Security Number: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Daytime phone: _____

SURVIVORSHIP *(check one)*:

[ ] I am filing the petition as a survivor of the individual in Section A –OR –

[ ] I am filing the petition as a survivor of the person in Section B

NATURE OF THE SURVIVOR'S RELATIONSHIP TO THE INDIVIDUAL IN SECTION A OR THE PERSON IN SECTION B *(check one)*:

[ ] Lawful husband or wife at the time of the person's death, and I attest, to the best of my knowledge, that the person with HIV and I were married according to the laws of the place where the person with HIV and I resided at the time of his/her death

[ ] Child or stepchild and there is no surviving spouse

[ ] Parent and there is no surviving spouse or surviving children

SURVIVING CHILDREN AND PARENTS MUST CHECK THE APPROPRIATE BOX *(check one)*:

[ ] To the best of my knowledge, there are no other survivors who are eligible for payment under the Act (i.e., for child survivors, there is no eligible surviving spouse and no other surviving children; for parent survivors, there are no eligible surviving spouses, surviving children, or other surviving parent);

[ ] There are other survivors who are eligible for payment under the Act. I am providing all of their full names and their relationship to the person we survived.
If this box is checked, list survivors:

Name: _____ Name: _____
Relationship: _____ Relationship: _____

Name: _____ Name: _____
Relationship: _____ Relationship: _____

(If you need more space, add another page listing all of the eligible survivors as described above.)

AMENDMENT TO A PREVIOUSLY SUBMITTED PETITION

Use only if the following applies to you. If so, check the box and provide the name requested.

- **If you are a survivor of an individual who has already submitted a petition, but who died before receiving a compassionate payment, please check the box below and fill in the name of that deceased person.**
- **If another survivor filed a petition or an amendment to a previously submitted petition, but then died before receiving a payment, check the box below and fill in the name of that deceased person.**
- **If the original petition was filed by multiple surviving children or parents and any of those survivors has died, check the box below and fill in the name of the survivor who filed the previous petition.**

[ ] I am amending the petition previously submitted by _____.

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SECTION D. PERSONAL REPRESENTATIVE

Complete this section if you are the attorney or other representative for the eligible individual. If this section is completed, all communications related to this petition will go to the personal representative.

Check instructions for Section D.

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Daytime phone: _____ Filing for: _____

Nature of relationship to eligible individual (e.g., attorney, guardian, other): _____

Does the eligible individual have the legal capacity to receive payments?

[ ] Yes – OR –

[ ] No. (e.g., a minor or an individual who is otherwise incompetent).

If no, please explain: _____

Signature of Personal Representative: _____

SECTION E. SIGNATURE OF PETITIONER

This section is required of all petitioners

Check the instructions for Section E.

Reminder: Attach all necessary documentation. See Documentation Checklist.

I swear or affirm under penalty of perjury that the information in this petition and all submitted documentation is true and correct to the best of my knowledge, information, and belief (18 USC §1621).

Name (printed clearly or typed): _____

Signature: _____ Date: _____

Submit this petition and the required medical and legal documentation to: Ricky Ray Program Office
Bureau of Health Professions
5600 Fishers Lane, Room 8A-54
Rockville, MD 20857

PUBLIC BURDEN STATEMENT

An agency may not conduct or sponsor, and any person is not required to respond to, a collection of information unless it displays a currently valid OMB Control Number. The OMB Control Number for this project is 0915-0244. Public reporting burden for this collection of information is estimated to average 3 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information.

RICKY RAY HEMOPHILIA RELIEF FUND
PETITION INSTRUCTIONS

The U.S. Congress enacted the Ricky Ray Hemophilia Relief Fund Act in 1998 (the Act) to make compassionate payments of $100,000 to certain individuals with blood-clotting disorders, such as hemophilia, who were treated with antihemophilic factor between July 1, 1982, and December 31, 1987, and contracted HIV. Such individuals must have been treated with the antihemophilic factor in any State of the United States of America, the District of Columbia, U.S. territories, commonwealths and possessions, or at any diplomatic area or military installation of the United States. Husbands and wives who contracted HIV from those individuals; children who acquired HIV from their mothers during pregnancy, delivery, or breast feeding; and certain surviving family members may also be eligible for payments.

A. Complete the relevant sections of the petition. ***All petitioners must complete Section A***, which requests information regarding the individual with the blood-clotting disorder and HIV. *All information you supply will be kept strictly confidential in accordance with the Privacy Act, and will be used solely to determine your eligibility to receive payments under the Ricky Ray Hemophilia Relief Fund Act.* For more information, consult the Notification of New System of Records, 64 Fed. Reg. 69,274 (Dec. 10, 1999).

B. Consult the Documentation Checklist for the category that best describes you. Then provide the required medical and legal documentation listed with your category to support your petition. This documentation must be submitted before your petition may be approved for payment.

C. Send your completed petition package to:

The Ricky Ray Program Office
Bureau of Health Professions
5600 Fishers Lane, Room 8A-54
Rockville, MD 20857

All petitions must be postmarked or accompanied by a receipt from a commercial carrier or the U.S. Postal Service no sooner than July 31, 2000 and no later than November 13, 2001. Petitions postmarked before July 31, 2000 or after November 13, 2001 will be returned unopened.

GENERAL INSTRUCTIONS FOR ALL PETITIONERS

1. A separate petition must be submitted for each HIV-infected person who is eligible for payment (the individual with a blood-clotting disorder, the lawful spouse, the former lawful spouse or the child).

2. If you qualify for multiple payments (e.g., you are an eligible, HIV-infected person and you are a survivor of another HIV-infected person; you are a survivor of two HIV-infected persons), you must submit a separate petition for each claim.

(General Instructions continued, next page)

If you have any questions, go to the Ricky Ray web-site, www.hrsa.gov/bhpr/rickyray, or call the toll-free number, 1-888-496-0338.

3. Multiple surviving children or surviving parents may submit one joint petition for the one, shared payment (e.g., the surviving children when there is no surviving spouse, or the surviving parents when there is no surviving spouse or surviving children). Survivors may also submit separate petitions.

4. Keep a copy of all forms and documentation for your own records.

CHANGES IN INFORMATION PROVIDED

Should there be a change in the information you provided with your Petition, you are required to notify the Ricky Ray Program Office at the address above. Please note that if you fail to provide us with this information, we may not be able to contact you directly with information on the next steps in processing your petition.

FILLING OUT THE PETITION

SECTION A – INSTRUCTIONS

This section is required for all petitioners

This section describes the individual with a blood-clotting disorder, who was treated with antihemophilic factor, and who has HIV. Enter the requested information.

- **Name**: The full name of the individual with a blood-clotting disorder and HIV.
- **Social Security Number**: That individual's 9-digit Social Security Number.
- **Date of Birth**: That individual's date of birth (month, day, and year).
- **If the individual is no longer living, provide the date of death:** That individual's date of death, if applicable (month, day, and year).
- **If the individual with a blood-clotting disorder and HIV is living**:
  - **Address:** That individual's current home address.
  - **City:** That individual's current city of residence.
  - **State**: That individual's current state of residence.
  - **Zip:** The 5 or 9 digit zip code of that individual's current residence.
  - **Daytime phone**: That individual's daytime telephone number, including the area code.

  If the individual with a blood-clotting disorder and HIV lives outside of the United States of America, in the State field, enter the country. In the Zip field, use any applicable mailing code. In the phone field, include the international dialing code for the country.

If you have any questions, go to the Ricky Ray web-site, www.hrsa.gov/bhpr/rickyray, or call the toll-free number, 1-888-496-0338.

SECTION B – INSTRUCTIONS

Complete this section if you are the lawful spouse with HIV of the individual with a blood-clotting disorder and HIV, a former lawful spouse with HIV, a child who acquired HIV through perinatal transmission, or their survivor(s)

This section describes a lawful spouse with HIV, a former lawful spouse with HIV, or a child who acquired HIV perinatally. Enter the requested information.

- **Name:** The full name of the lawful spouse with HIV, the former lawful spouse with HIV, or the child who acquired HIV through perinatal transmission.
- **Social Security Number**: That person's 9-digit Social Security Number.
- **Date of Birth**: That person's date of birth (month, day, and year).
- **If the individual is no longer living, provide the date of death**. That person's date of death, if applicable (month, day, and year).
- **If the person is living**:
  - **Address:** That person's current home address.
  - **City:** That's person's current city of residence.
  - **State**: That person's current state of residence.
  - **Zip:** 5 or 9 digit zip code of that person's current residence.
  - **Daytime phone**: The daytime telephone number, including the area code.

  If the lawful spouse with HIV, the former lawful spouse with HIV, or the child who acquired HIV perinatally lives outside of the United States of America, in the State field, enter the country. In the Zip field, use any applicable mailing code. In the phone field, include the international dialing code for the country.
- **Relationship to individual in Section A (Check one):** Check the appropriate box indicating whether the person identified in Section B is the lawful spouse (husband or wife) with HIV; the former lawful spouse (husband or wife) with HIV, or the child with HIV. If the person identified in Section B is the child with HIV, check the third box if the individual identified in Section A is the child's birth mother; check the fourth box if the child's birth mother is the lawful spouse of the individual identified in Section A; check the fifth box if the child's birth mother was the former lawful spouse of the individual identified in Section A. Note that a child with HIV who checked the fifth box may be eligible for payment even if the individual identified in Section A is not the child's father.

SECTION C – INSTRUCTIONS

Complete this section if you are filing a petition as a survivor

This section describes a surviving spouse, child, or parent of a deceased person with HIV. The lawful spouse can always file a petition. The surviving child or children can file a petition if there is no surviving spouse. The surviving parent or parents can file a petition if there is no surviving spouse or are no surviving children. Enter the requested information.

(Section C continued, next page)

If you have any questions, go to the Ricky Ray web-site, www.hrsa.gov/bhpr/rickyray, or call the toll-free number, 1-888-496-0338.

- **Name:** The survivor's full name.
- **Social Security Number**: The survivor's 9-digit Social Security Number.
- **Date of Birth**: The survivor's date of birth (month, day, and year).
- **Address:** The survivor's current home address.
- **City:** The survivor's current city of residence.
- **State**: The survivor's current state of residence.
- **Zip:** 5 or 9 digit zip code of the survivor's current residence.
- **Daytime phone**: The survivor's daytime telephone number, including the area code.

If the survivor filing the petition lives outside of the United States of America, in the State field, enter the country. In the Zip field, use any applicable mailing code. In the phone field, include the international code for the country.

- **Survivorship (check one)**: Check the first box if you are a survivor of the individual with HIV and a blood-clotting disorder. Check the second box if you are a survivor of a person with HIV who is not the individual with a blood-clotting disorder (e.g., the lawful spouse, the former lawful spouse or the child). If you are a survivor of both, you may be eligible for two payments. In that case, file two separate petitions; check the first box in one petition and the second box in the other.
- **Nature of the survivor's relationship to the individual in Section A or the person in Section B (check one):** Check the appropriate box to indicate whether you were the lawful husband or wife at the time of the death of the person with HIV; the child or stepchild, where there is no surviving spouse; or the parent, where there is no surviving spouse or surviving children.
- **Surviving children or parents (check one):** Check the first box if you are the only survivor of the person with HIV who is eligible for payment under the Act. Check the second box if there are other eligible survivors. If you checked the second box, provide further information for each of the other eligible survivors:

  – **Name**: The name of the survivor(s) other than yourself; and

  – **Relationship**: The relationship to the person with HIV who died. (e.g., child, parent).

  Four areas are provided on the form. If you need more space, use additional paper and list all eligible survivors.

AMENDMENT TO A PREVIOUSLY SUBMITTED PETITION – INSTRUCTIONS

Complete this section only if you are a survivor amending a petition

Under three specific circumstances described below, survivors of persons with HIV must file an amendment to a previously submitted petition in order to retain the original assigned order number and to receive payment under the Act. Survivors must use the petition form to amend a petition. If you meet any of the three circumstances, check the box and fill in the full name of the petitioner whose petition you are amending.

- If you are a survivor of a person who has already submitted a petition, but who died before receiving a compassionate payment, check the box and fill in the name of that deceased individual.

(Amendment continued, next page)

If you have any questions, go to the Ricky Ray web-site, www.hrsa.gov/bhpr/rickyray, or call the toll-free number, 1-888-496-0338.

- If another survivor filed a petition or an amendment to a previously submitted petition, but then died before receiving a payment, check the box and fill in the name of that deceased person.
- If the original petition was filed by multiple surviving children or parents and any of those survivors has died, check the box and fill in the name of the survivor who filed the previous petition.

SECTION D – INSTRUCTIONS

Complete this section if you are a personal representative of any eligible individual

This section describes an attorney or other representative for the eligible individual, if any. If this section is completed, all communications related to the petition will go directly to the personal representative. Enter the requested information.

- **Name:** The personal representative's full name.
- **Address:** The personal representative's current home or office address.
- **City:** The personal representative's current city of office or residence.
- **State**: The personal representative's current state of office or residence.
- **Zip:** 5 or 9 digit zip code of the personal representative's current office or residence.
- **Daytime phone**: The daytime telephone number of the personal representative, including the area code.
- **Filing for:** The name of the eligible individual on whose behalf you are filing a petition.
- **Nature of relationship to eligible individual**. Fill in the blank indicating attorney, guardian or other (be specific).
- **Does the eligible individual have the legal capacity to receive payments?** Check the "Yes" box if the person you are representing has the legal capacity. Check the "No" box if the person you are representing does not have the legal capacity to receive payments (e.g., you represent a minor or an individual who is otherwise incompetent). In the space provided, please explain.

If the personal representative lives or works outside of the United States of America, in the State field, enter the country. In the Zip field, use any applicable mailing code. In the phone field, include the international dialing code for the country.

- **Signature of Personal Representative:** The personal representative's original signature in ink.

SECTION E – INSTRUCTIONS

All petitioners or their representatives must complete this section

All eligible individuals must sign the petition, unless he/she does not have the legal capacity to receive payments under the Act. In that case, a personal representative must sign for the individual (even if the personal representative also signed in Section D above). If multiple surviving children or surviving parents are filing jointly, at least one of these survivors must sign the petition. Enter the requested information.

- **Name (printed clearly or typed):** The name of the person signing the petition, presented legibly.

(Section E continued, next page)

If you have any questions, go to the Ricky Ray web-site, www.hrsa.gov/bhpr/rickyray, or call the toll-free number, 1-888-496-0338.

- **Signature:** An original signature in ink.
- **Date:** Date petition was signed (month, day, and year).

USE OF SOCIAL SECURITY NUMBERS

Pursuant to the Debt Collection Improvement Act of 1996, and in furtherance of the Ricky Ray Hemophilia Relief Fund Act of 1998, the Petition asks petitioners to provide social security account numbers. This information will be used by the Department of Health and Human Services to verify the identity of individuals filing petitions and to determine their eligibility for payment. This information will also be used by the Department of the Treasury to transmit payment data, by electronic means, to the financial institutions of individuals deemed eligible for a compassionate payment. Furnishing this information on the Petition is voluntary, but failure to do so may delay or prevent the receipt of a compassionate payment.

If you have any questions, go to the Ricky Ray web-site, www.hrsa.gov/bhpr/rickyray, or call the toll-free number, 1-888-496-0338.

RICKY RAY HEMOPHILIA RELIEF FUND
PETITION DOCUMENTATION CHECKLIST

To determine the documentation you need to complete your petition, please check those options below that apply to you, and provide the documentation as described. Also, all petitions must be filled out completely and signed under penalty of perjury.

CHECK BOX	CATEGORY OF ELIGIBILITY	REQUIRED DOCUMENTATION
	1. PERSONS WITH HIV	
☐	**The individual with a blood-clotting disorder and HIV.** An HIV infected individual who has a blood-clotting disorder, such as hemophilia, who was treated with antihemophilic factor at any time during the period from July 1, 1982, to December 31, 1987, in any state of the United States of America, the District of Columbia, U.S. territories, commonwealths, and possessions, or at any diplomatic area or military installation of the United States.	**Medical documentation showing that the individual with a blood-clotting disorder and HIV:** (1) has a blood-clotting disorder, such as hemophilia; (2) was treated with antihemophilic factor at any time between July 1, 1982, and December 31, 1987; and (3) has an HIV infection. This medical documentation may be submitted in the following forms: (a) copies of relevant portions of medical records, records maintained by a doctor, nurse, or other licensed health care provider, test results, prescription information, or other documentation possibly deemed credible by the Secretary (e.g., infusion logs and packing slips); or (b) an affidavit, signed under penalty of perjury, by a doctor or nurse practitioner, verifying that the medical criteria necessary for a petitioner to be eligible for payment under the Act are satisfied. The affidavit must include the doctor's or nurse practitioner's state and license number. The affidavit is contained in Appendix B.

If you have any questions, go to the Ricky Ray web-site, www.hrsa.gov/bhpr/rickyray, or call the toll-free number, 1-888-496-0338.

CHECK BOX	CATEGORY OF ELIGIBILITY	REQUIRED DOCUMENTATION
	PERSONS WITH HIV *(Continued)*	
☐	**The lawful spouse with HIV.** An HIV infected person who is the lawful spouse of an individual with a blood-clotting disorder and HIV, according to the laws of the place where the lawful spouse resides on the date this petition is filed.	**Medical documentation showing that the individual with a blood-clotting disorder and HIV:** (1) has (or had) a blood-clotting disorder, such as hemophilia; (2) was treated with antihemophilic factor at any time between July 1, 1982, and December 31, 1987; and (3) has (or had) an HIV infection. **Medical documentation showing that the lawful spouse with HIV has an HIV infection.** The required medical documentation may be submitted in the following forms: (a) copies of relevant portions of medical records, records maintained by a doctor, nurse, or other licensed health care provider, test results, prescription information, or other documentation possibly deemed credible by the Secretary (e.g., infusion logs and packing slips); or (b) an affidavit, signed under penalty of perjury, by a doctor or nurse practitioner, verifying that the medical criteria necessary for a petitioner to be eligible for payment under the Act are satisfied. The affidavit must include the doctor's or nurse practitioner's state and license number. This affidavit is contained in Appendix B. **Legal documentation**: A marriage certificate or other proof of a lawful marriage that shows that the lawful spouse with HIV and the individual with a blood-clotting disorder and HIV are married.

If you have any questions, go to the Ricky Ray web-site, www.hrsa.gov/bhpr/rickyray, or call the toll-free number, 1-888-496-0338.

CHECK BOX	CATEGORY OF ELIGIBILITY	REQUIRED DOCUMENTATION
	PERSONS WITH HIV *(Continued)*	
☐	**The former lawful spouse with HIV.** An HIV infected person who is the former lawful spouse of the individual with a blood-clotting disorder and HIV and (1) was the lawful spouse of the individual with a blood-clotting disorder and HIV at any time after the date of the individual's treatment with antihemophilic factor (this date of treatment must have been between July 1, 1982, and December 31, 1987), and (2) is no longer married	**Medical documentation showing that the individual with a blood-clotting disorder and HIV:** (1) has (or had) a blood-clotting disorder, such as hemophilia; (2) was treated with antihemophilic factor at any time between July 1, 1982, and December 31, 1987; and (3) has (or had) an HIV infection. **Medical documentation showing that the former lawful spouse with HIV:** (1) has an HIV infection; and (2) with reasonable certainty contracted HIV from the individual with a blood-clotting disorder and HIV. The required medical documentation may be submitted in the following forms: (a) copies of relevant portions of medical records, records maintained by a doctor, nurse, or other licensed health care provider, test results, prescription information, or other documentation possibly deemed credible by the Secretary (e.g., infusion logs and packing slips); or (b) an affidavit, signed under penalty of perjury, by a doctor or nurse practitioner, verifying that the medical criteria necessary for a petitioner to be eligible for payment under the Act are satisfied. The affidavit must include the doctor's or nurse practitioner's state and license number. The affidavit is contained in Appendix B. **Legal documentation:** (1) A marriage certificate or other proof of a lawful marriage, which shows that the former lawful spouse with HIV and the individual with a blood-clotting disorder and HIV were married at any time after the date of the individual's treatment with antihemophilic factor (this date of treatment must have been between July 1, 1982, and December 31, 1987); and (2) A divorce certificate or other proof of termination of the marriage.

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CHECK BOX	CATEGORY OF ELIGIBILITY	REQUIRED DOCUMENTATION
	PERSONS WITH HIV *(Continued)*	
☐	**The child with HIV** who acquired an HIV infection through perinatal transmission from a mother who is the individual with a blood-clotting disorder and HIV.	**Medical documentation showing that the individual with a blood-clotting disorder and HIV:** (1) has (or had) a blood-clotting disorder, such as hemophilia; (2) was treated with antihemophilic factor at any time between July 1, 1982, and December 31, 1987; and (3) has (or had) an HIV infection. **Medical documentation showing that the child with HIV**: (1) has an HIV infection; and (2) acquired an HIV infection through perinatal transmission from a birth mother who is the individual with a blood-clotting disorder and HIV. The required medical documentation may be submitted in the following forms: (a) copies of relevant portions of medical records, records maintained by a doctor, nurse, or other licensed health care provider, test results, prescription information, or other documentation possibly deemed credible by the Secretary (e.g., infusion logs and packing slips); or (b) an affidavit, signed under penalty of perjury, by a doctor or nurse practitioner, verifying that the medical criteria necessary for a petitioner to be eligible for payment under the Act are satisfied. The affidavit must include the doctor's or nurse practitioner's state and license number. The affidavit is contained in Appendix B. **Legal documentation:** A birth certificate or other proof showing that the child with HIV is the child of a mother, who is the individual with a blood-clotting disorder and HIV.

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CHECK BOX	CATEGORY OF ELIGIBILITY	REQUIRED DOCUMENTATION
	PERSONS WITH HIV *(Continued)*	
☐	**The child with HIV** who acquired an HIV infection through perinatal transmission from a mother who is the lawful spouse of an individual with a blood-clotting disorder and HIV.	**Medical documentation showing that the individual with a blood-clotting disorder and HIV:** (1) has (or had) a blood-clotting disorder, such as hemophilia; (2) was treated with antihemophilic factor at any time between July 1, 1982, and December 31, 1987; and (3) has (or had) an HIV infection. **Medical documentation showing that the child with HIV**: (1) has an HIV infection; (2) acquired an HIV infection through perinatal transmission from a birth mother who is the lawful spouse with HIV. The required medical documentation may be submitted in the following forms: (a) copies of relevant portions of medical records, records maintained by a doctor, nurse, or other licensed health care provider, test results, prescription information, or other documentation possibly deemed credible by the Secretary (e.g., infusion logs and packing slips); or (b) an affidavit, signed under penalty of perjury, by a doctor or nurse practitioner, verifying that the medical criteria necessary for a petitioner to be eligible for payment under the Act are satisfied. The affidavit must include the doctor's or nurse practitioner's state and license number. The affidavit is contained in Appendix B. **Legal documentation:** a) A birth certificate or other proof showing that the child with HIV is the child of the mother with HIV; and b) A marriage certificate or other proof showing that the father with the blood-clotting disorder and HIV and the mother with HIV were lawfully married.

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CHECK BOX	CATEGORY OF ELIGIBILITY	REQUIRED DOCUMENTATION
	PERSONS WITH HIV *(Continued)*	
☐	**The child with HIV** who acquired an HIV infection through perinatal transmission from a mother who is the former lawful spouse of an individual with a blood-clotting disorder and HIV.	**Medical documentation showing that the individual with a blood-clotting disorder and HIV:** (1) has (or had) a blood-clotting disorder, such as hemophilia; (2) was treated with antihemophilic factor at any time between July 1, 1982, and December 31, 1987; and (3) has (or had) an HIV infection. **Medical Documentation showing that the child with HIV**: (1) has an HIV infection; and (2) acquired an HIV infection through perinatal transmission from a birth mother who is/was the former lawful spouse with HIV. **Medical documentation showing that the mother with HIV**: with reasonable certainty contracted HIV from the individual with a blood-clotting disorder and HIV. The required medical documentation may be submitted in the following forms: (a) copies of relevant portions of medical records, records maintained by a doctor, nurse, or other licensed health care provider, test results, prescription information, or other documentation possibly deemed credible by the Secretary (e.g., infusion logs and packing slips); or (b) an affidavit, signed under penalty of perjury, by a doctor or nurse practitioner, verifying that the medical criteria necessary for a petitioner to be eligible for payment under the Act are satisfied. The affidavit must include the doctor's or nurse practitioner's state and license number. The affidavit is contained in Appendix B. **Legal documentation:** a) A birth certificate or other proof showing that the child with HIV is the child of the mother with HIV; and b) A marriage certificate or other proof showing that the man with the blood-clotting disorder and HIV and the mother with HIV were lawfully married.

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CHECK BOX	CATEGORY OF ELIGIBILITY	REQUIRED DOCUMENTATION
	2. SURVIVORS OF PERSONS WITH HIV	
☐	**Surviving spouse of a person with HIV.**	**All medical and legal documentation** required for the person with HIV (i.e., the individual with a blood-clotting disorder and HIV, the lawful spouse with HIV, the former lawful spouse with HIV, or the child with HIV), as described in Section 1 above. **Legal documentation**: (1) a death certificate for the person with HIV, or other evidence of that person's death; and (2) a marriage certificate or other proof of lawful marriage, which shows that you were the spouse of the person with HIV.
☐	**Surviving child or children of a person with HIV.**	**All medical and legal documentation** required for the person with HIV (i.e., the individual with a blood-clotting disorder and HIV, the lawful spouse with HIV, the former lawful spouse with HIV, or the child with HIV), as described in Section 1 above. **Legal documentation:** (1) a death certificate for the person with HIV, or other evidence of that person's death; and (2) a birth certificate, adoption certificate, documentation showing that you are the stepchild of the person with HIV (i.e., a certificate of marriage between your parent and the person with HIV), or other documentation showing that you are the child of the person with HIV.
☐	**Surviving parent or parents of a person with HIV.**	**All medical and legal documentation** required for the person with HIV (i.e., the individual with a blood-clotting disorder and HIV, the lawful spouse with HIV, the former lawful spouse with HIV, or the child with HIV), as described in Section 1 above. **Legal documentation:** (1) a death certificate for the person with HIV, or other evidence of that person's death; and (2) for each surviving parent, a birth certificate, adoption certificate, or other documentation which shows that you are the parent of the person with HIV.

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CHECK BOX	CATEGORY OF ELIGIBILITY	REQUIRED DOCUMENTATION
3. SURVIVORS FILING AN AMENDMENT TO A PRIOR PETITION		
☐	**Survivor or survivors of a person with HIV where the person with HIV filed a petition, but then died before receiving payment.**	**Legal documentation for spouse survivors:** (1) a death certificate for the person with HIV, or other evidence of that person's death; and (2) a marriage certificate or other proof of lawful marriage, which shows that you were the spouse of the person with HIV. **Legal documentation for child survivors:** (1) a death certificate for the person with HIV, or other evidence of that person's death; (2) for each surviving child, a birth certificate, adoption certificate, documentation that shows that you are the stepchild of the person with HIV (i.e., a certificate of marriage between your parent and the person with HIV), or other documentation which shows that you are the child of the person with HIV. **Legal documentation for parent survivors:** (1) a death certificate for the person with HIV, or other evidence of that person's death; and (2) for each surviving parent, a birth certificate, adoption certificate, or other documentation which shows that you are the parent of the person with HIV.

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CHECK BOX	CATEGORY OF ELIGIBILITY	REQUIRED DOCUMENTATION
	SURVIVORS FILING AN AMENDMENT TO A PRIOR PETITION *(Continued)*	
☐	**The next eligible survivor or survivors of a person with HIV where another survivor filed a petition or an amendment to a petition, but then died before receiving payment.**	**Legal documentation for spouse survivors:** (1) a death certificate for the person with HIV, or other evidence of that person's death; (2) a marriage certificate or other proof of lawful marriage, which shows that you were the spouse of the person with HIV; and (3) a death certificate for the person who was listed as a survivor on the original petition or amendment who has died, or other evidence of that person's death. **Legal documentation for child survivors:** (1) a death certificate for the person with HIV, or other evidence of that person's death; (2) for each surviving child, a birth certificate, adoption certificate, documentation that shows that you are the stepchild of the child with HIV (i.e., a certificate of marriage between your parent and the person with HIV), or other documentation which shows that you are the child of the person with HIV; and (3) a death certificate for the person who was listed as a survivor on the original petition or amendment who has died, or other evidence of that person's death. **Legal documentation for parent survivors:** (1) a death certificate for the person with HIV, or other evidence of that person's death; (2) for each surviving parent, a birth certificate, adoption certificate, or other documentation which shows that you are the parent(s) of the person with HIV; and (3) a death certificate for the person who was listed as a survivor on the original petition or amendment who has died, or other evidence of that person's death.
☐	**Survivor or survivors of a person with HIV where multiple surviving children or surviving parents filed a petition, but one of the survivors died before receiving payment.**	**Legal documentation:** A death certificate for the person who was listed as a survivor on the original petition or amendment who has died, or other evidence of that person's death.

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CHECK BOX	CATEGORY OF ELIGIBILITY	REQUIRED DOCUMENTATION
	4. PERSONAL REPRESENTATIVES	
☐	**Personal Representatives:** Personal representatives may file a petition for an individual who is eligible to receive payment under the Act: (1) where the eligible individual does not have the legal capacity to receive payment under the Act, as described in §130.35(e); or (2) where the eligible individual does have the capacity to receive payment under the Act, but only if the sworn statement included at the end of the petition is signed by the eligible individual.	**In all cases, the personal representative must submit all medical and legal documentation required for the eligible individual.** In those cases in which the eligible individual does not have the legal capacity to receive payment under the Act, a personal representative may receive payment for a legally incompetent individual by submitting the following written documentation: (1) proof showing the eligible individual does not have the legal capacity to receive payment under the Act (e.g., a birth certificate showing that the eligible individual is a minor or other evidence showing that the eligible individual is legally incompetent); and (2) proof showing that you have the authority to receive payment for the eligible individual (e.g., proof of legal guardianship).

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PARTS 131–135 [RESERVED]