

OHIO HIV DRUG ASSISTANCE PROGRAM

APPLICATION FORM

App Start Date: _____

App End Date: _____

Please indicate program(s) for which you are applying. Check ALL that apply:

OHDAP (Ohio HIV Drug Assistance Program)	HIPP Program (Health Insurance Premium Payment)	Ohio Medicaid Spenddown Payment Program
<input type="checkbox"/> Formulary <input type="checkbox"/> Single Drug (specify): _____ <input type="checkbox"/> Co-Pays (for Private Health Insurance) <input type="checkbox"/> Co-Pays (for Medicaid) <input type="checkbox"/> Co-Pays (for Medicare)	<input type="checkbox"/> Private Health Insurance Premiums <input type="checkbox"/> COBRA Policy Premiums <input type="checkbox"/> Medicare Part D Policy Premiums	<input type="checkbox"/> Monthly Spenddown <input type="checkbox"/> Emergency Spenddown <p style="text-align: center; font-size: small;"><i>For those who also have Medicare, a rationale for monthly spenddown payments must be provided.</i></p>
<p><i>In order to qualify for any type of co-pay or premium assistance, complete insurance information must be provided.</i></p> <p>Application can not be processed without this information.</p>		

A. DEMOGRAPHIC INFORMATION

Application Date: ____ ____ 20 ____		Social Security No: _____ - _____ - _____	
First Name _____		Middle Name _____	
Last Name _____		<input type="checkbox"/> Junior <input type="checkbox"/> Senior	
Address: _____		Apt. _____	
<input type="checkbox"/> (check if new address since last application)			
City: _____		State: OHIO	
ZIP: _____		County: _____	
Home Phone: () - _____		Work Phone: () - _____	
May we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No		May we call you at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Cell Phone: () - _____		Email Address (include only if we can contact you via email): _____	
May we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Emergency Contact* Name and Phone (____) _____ - _____			
Relationship: _____		<i>*This must be someone we can contact!</i>	
Sex	Ethnicity	Race (Please check all that apply)	
<input type="checkbox"/> Male	<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Amer. Indian or Alaska Native	
<input type="checkbox"/> Female	<input type="checkbox"/> Non Hispanic/Latino	<input type="checkbox"/> Asian	
<input type="checkbox"/> Transgender		<input type="checkbox"/> Black or African American	
		<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	
		<input type="checkbox"/> White	
Date of Birth): ____ / ____ / ____		Year of first positive HIV Test): ____ ____ ____	
Name and phone number of person (if any) who helped you complete this application: _____			Referral:
(____) _____ - _____			<input type="checkbox"/> MAI
			<input type="checkbox"/> CLC

B. CASE MANAGEMENT

Applicants with income less than 100% of the current the Federal Poverty Level are required to have a case manager's signature.

Case Manager	Agency	Phone Number

I certify that the above-named applicant has entered into case management with our agency and has been assessed to have a need for the program(s) for which he/she is applying.

Case Manager Signature _____

Date _____

This client's primary language is **NOT** English. Specify: _____

C. PUBLIC ASSISTANCE

I have **applied** for the program(s) below.
Check all that apply

I am **receiving** the program(s) below.
Check all that apply.

Medicaid *Applicants with income less than 100% of the current the Federal Poverty Level are required to apply for Medicaid*

Application Date: _____
(Date is not necessary if you are receiving Medicaid)

Medicare

Part A Application Date: _____
 Part B Application Date: _____
 Part D Application Date: _____

(Dates are not necessary if you are receiving Medicare)

Social Security Disability Income (SSDI)
 Supplemental Security Income (SSI)

Veteran's Benefits

I have not applied for any of the programs above because:

Medicaid

Monthly Medicaid spend down \$ _____

Please VERIFY as this is the amount we will pay if you are eligible for this program.

Medicaid Case Number: _____

Medicaid Billing Number: _____

Medicare

Part A
 Part B
 Part D

Social Security Disability Income (SSDI)
 Supplemental Security Income (SSI)

Veteran's Benefits

Please submit official documentation regarding your Medicaid and Medicare applications (approval/denial letters) with your OHDAP application to avoid termination of benefits.

D. HOUSEHOLD INCOME INFORMATION

Proof of income must be provided for ALL members of the family, this includes married spouses and children under the age of 18. Please complete the following for all additional individuals living in the home with you.

Name	Age	Relationship	Same Address?	Covered by Insurance?	Also OHDAP Client?

Below, please write in the amount received (gross) **each month**

Income Type	Applicant	Other Household Members
Salary/Wages	\$	\$
Private Disability Income	\$	\$
Social Security Disability Income	\$	\$
Supplemental Security Income	\$	\$
Veterans' Benefits per month	\$	\$
Other Income per month	\$	\$
Circle those that apply: Alimony/child support, pension, unemployment, workers' compensation, rental income, other [specify]	\$	\$
<i>If you report income at or below the federal poverty level, please sign a "Verification of Income Statement" with your case manager.</i>		

Employment Status (Check all that apply): <input type="checkbox"/> Full-time (40 or more hours per week) <input type="checkbox"/> Part-time <input type="checkbox"/> Self Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Medically Disabled <input type="checkbox"/> Retired	I am paid every: <input type="checkbox"/> Week <input type="checkbox"/> Two (2) Weeks <input type="checkbox"/> Month <input type="checkbox"/> Other	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Legally Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
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CLIENT	One of the following: <input type="checkbox"/> Copies of paychecks (4 recent consecutive weeks within last 45 days—for all applicants who work) <input type="checkbox"/> Social Security Benefit/Award letter <input type="checkbox"/> Other (specify):	AND	<input type="checkbox"/> An IRS tax transcript form from the most recent tax year is required for ALL APPLICANTS WHO WORK. YEAR: 20____ ____
SPOUSE	One of the following: <input type="checkbox"/> Copies of paychecks (4 recent consecutive weeks within last 45 days—for all spouses who work) <input type="checkbox"/> Social Security Benefit/Award letter <input type="checkbox"/> Other (specify):	AND	<input type="checkbox"/> An IRS tax transcript form from the most recent tax year is required for ALL APPLICANTS WITH SPOUSES WHO WORK. YEAR: 20____ ____

E. INSURANCE INFORMATION

Applicants for **ALL** programs must complete this section. Providing incomplete or inaccurate information regarding coverage may result in not being approved/being terminated from our programs.

<p>I have health insurance coverage through:</p> <p><input type="checkbox"/> Private Insurance Policy</p> <p><input type="checkbox"/> COBRA <i>(If checked, see box at right)</i></p> <p><input type="checkbox"/> Medicare</p> <p><input type="checkbox"/> Medicaid</p> <p><input type="checkbox"/> Other</p> <p><input type="checkbox"/> I don't have any health insurance coverage <i>(Continue application with the Authorization for Proof and Release of Information section)</i></p>	<p>If you have a COBRA Policy, please complete information below:</p> <p>COBRA Start Date: _____</p> <p>COBRA End Date: _____</p> <p><input type="checkbox"/> Attach copy of your COBRA election form.</p>
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Insurance Policy Holder Name (if not applicant):
Insurance Policy Holder SSN (if not applicant):
Applicant Relationship to Policy Holder:
Policy Number:

PLEASE NOTE: You are responsible for payments (of spenddowns and premiums) until notified that the Ohio Department of Health will begin third party payment. If the insurance rate and/or address of payment change, you must give us documentation of the change. We **CAN NOT** make payments without the following information:

MAIL PREMIUM PAYMENTS TO:

Name:		
Address (cannot be client's address):		
City, State, Zip:		
Phone Number:	Contact Person:	Title:
Federal Tax ID Number (9 Digits)		
Employer Providing Coverage:		
Phone Number:	Contact Person:	Title:

Insurance coverage includes (check all that apply):	Monthly Premium Amounts
<input type="checkbox"/> Prescriptions (if yes, complete Prescription Coverage Section below)	\$
<input type="checkbox"/> Dental	\$
<input type="checkbox"/> Vision	\$
<input type="checkbox"/> Hospitalization and Major Medical	\$
How many people are covered under this policy?	Monthly Premium Total \$

F. PRESCRIPTION COVERAGE

Please share with us what type of prescription coverage you have (check all that apply):

Percentage Payment	Flat Fee
<input type="checkbox"/> I must pay for _____% of my prescription medications.	<input type="checkbox"/> I have a co-payment of \$_____ per each PREFERRED Brand Named Drug
<input type="checkbox"/> I must pay 100% up front and wait for reimbursement of _____. [Non-Assignable]	I have a co-payment of \$_____ per each Brand Named Drug
	<input type="checkbox"/> I have a co-payment of \$_____ per each generic Drug
<input type="checkbox"/> I have a limit on prescription coverage of \$_____ per <input type="checkbox"/> month <input type="checkbox"/> year	

**Please include clear photocopy of front and back of insurance card
AND prescription card (if separate).**

INSURANCE PLAN NAME:
Member ID #/Rx ID #:
Rx BIN#:
Rx PCN:
Rx Group#:
Customer Service Phone Number:

INDIVIDUAL AUTHORIZATION FORM (HIPAA RELEASE)

INDIVIDUAL'S INFORMATION

Include information about the individual whose information will be released.

Name	DOB	Address
SSN	Member ID (on Insurance Card)	

RELEASE/RECEIVE INFORMATION

Insert the person/organization allowed to release the information and the person/organization allowed to receive the information.

The following company is allowed to release the information requested (insert name of insurance company/employer if company is self-insured):

The information can be provided to: Health Insurance Premium Payment (HIPP) Program
Ohio Department of Health, 246 N. High Street, Columbus, OH 43215
1-800-777-4775

WHAT INFORMATION IS BEING RELEASED

The HIPP program of the Ohio Department of Health is the third-party payer of my insurance premium. As a result, I give my permission for release of the following information:

- ▶ Premium Information
- ▶ Payment History
- ▶ Policy Information
- ▶ Prescription Drug Benefit Information
- ▶ Correct address information to ensure prompt payment

PURPOSE OF RELEASE

The purpose of this release is to ensure prompt payment of my insurance premiums. As such, any telephone calls from representatives of the HIPP program at the Ohio Department of Health will be in the interest of pursuing this effort.

EXPIRATION DATE

If not previously revoked in writing, this authorization will terminate three months from the date the individual's coverage ends.

SIGNATURE

A copy of this authorization is available to me upon request and will serve as the original. I understand that if this information is to be received by individuals or organizations that are not health care providers, health care clearinghouses or health plans covered by federal privacy regulations, my information described above may be re-disclosed by the recipient and no longer protected by federal privacy regulations. This authorization is subject to revocation at any time upon written notice to the person/company specified above except to the extent that the person/company has already taken action on the disclosure provisions contained in this document.

Signature of insured adult, parent/guardian of minor insured

Date: _____

Signature of legal representative of insured (if applicable)

Date: _____

If a legal representative of insured signs on behalf of the individual, a copy of the legal representative's authority must be attached to this form.

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION.

G. Authorization for Proof and Release of Information and HIV/AIDS Reporting

The number of HIV cases reported in Ohio determines funding for AIDS services. HIV/AIDS reporting has significant impact on the dollars available to assist individuals. Monies for the HIV Drug Assistance and HIPP Programs are granted to Ohio based upon the reported number of people living with HIV/AIDS.

Ohio law mandates that HIV and AIDS cases be reported to the Ohio Department of Health.

I understand that submitting this application to the Ohio HIV Drug Assistance Program and/or HIPP Programs will generate a confidential HIV/AIDS case report form to comply with Ohio law.

I authorize the Ohio Department of Health to verify all the information stated in this application relative to my medical condition, program eligibility status, financial income and available resources, insurance benefits, and other sources of assistance.

I understand that the Ohio Department of Health may communicate with my physician, case manager, my county Department of Job and Family Services office, my emergency contact, or other provider listed on this application to determine my eligibility for this program or to assist me in receiving services through this program.

I understand that I must inform the HIV Drug or HIPP Program if any of the information regarding my eligibility status changes in any way. I understand that providing false, incomplete or inaccurate information may result in termination or denial of benefits.

By my signature below, I affirm that to the best of my knowledge and belief, the answers and information furnished are complete and correct and that I agree to the release of my information to the necessary individuals and/or agencies as described above.

Signature of applicant (or guardian, if applicable):

Date of Signature:

[mm/dd/yy]

/ /

Signature of applicant or person legally responsible for the applicant (if the applicant is a minor or a disabled dependent) is required. This release is good for a period of two (2) years unless revoked by the applicant in writing.

Appeal Procedures

You have a right to appeal to the Director of the Ohio Department of Health if:

- 1) Your application for the Ohio HIV Drug Assistance or HIPP Program assistance is denied.
- 2) Your assistance via the Ohio HIV Drug Assistance or HIPP Program is terminated.

If you believe you have been discriminated against because of race, color, national origin, sex, age, handicap, religion or political belief, you have a right to file a complaint with the Ohio Department of Health, P.O. Box 118, Columbus, Ohio 43266-0118; or with the Secretary Department of Health and Human Services, Washington D.C. 20201.

Please send this report to:

**Ohio Department of Health
HIV CARE SERVICES Section
246 North High Street, 6th Floor
Columbus, OH 43216-0118
800. 777. 4775 [Phone]
866-448-6337 [Fax]**

PHYSICIAN VERIFICATION FORM FOR OHDAP

Patient Name: _____

Patient's Social Security Number (last 4 digits): **XXX-XX** -

Patient's DOB - -

Does this applicant have private medical insurance? Yes No

Test Type	RESULT		Date of most recent test [MM/DD/YYYY] Must be within the last 6 months
	Percentage	Absolute Value	
CD 4 Count			<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Viral Load			<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Labs have been drawn at current visit and are pending. Results will be available within 30 days and will be faxed/phoned to OHDAP by this office.

1. Has the patient been referred to an AIDS Clinical Trials Group?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Is patient receiving any medications through Clinical Trials?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Are you prescribing HIV medication (HAART) for this patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No
HIV Disease Staging	Level of Care
<i>Please check the appropriate box for this patient's lowest historic lab results:</i> <input type="checkbox"/> Stage 1 (CD4+ >500) <input type="checkbox"/> Stage 2 (CD4+ <500 and >200) <input type="checkbox"/> Stage 3 (CD4+ <200) <input type="checkbox"/> Stage 4 (For use only for a client who has recently tested positive and for whom no CD4/viral load information is available.)	<i>Please check the appropriate box:</i> <input type="checkbox"/> Well Generally <input type="checkbox"/> Intermittently ill, but able to perform activities of daily living <input type="checkbox"/> Intermittently ill, requires assistance with some (1-3) activities but generally able to care for self <input type="checkbox"/> Requires assistance with 3 or more activities of daily living and/or personal care <input type="checkbox"/> Unable to care for self and/or is bedridden <input type="checkbox"/> Requires equivalent of full-time, institutional care

Physician Signature _____ Date ____/____/____

Physician Name (please print legibly or type): _____

Office Address: _____

City: _____ State: _____ Zip: _____

Phone: (____) _____ - _____ Fax: (____) _____ - _____

Applications for the Ohio HIV Drug Assistance Program CANNOT be processed without this physician report. To help avoid treatment delays,

please fax this report PROMPTLY to OHDAP at 1-866-HIV-MEDS (866-448-6337)