OHIO HIV DRUG ASSISTANCE PROGRAM
APPLICATION FORM INSTRUCTIONS

At the top of the form, please indicate the program(s) for which you are applying.

A. DEMOGRAPHIC INFORMATION

Most of the information in this section is self-explanatory. Below is some additional information on parts that may need explanation.

Application Date: The date you are filling out the form.
Social Security Number: Please complete or leave blank if you do not have a social security number.
Email Address: Please include ONLY if you are willing to have us send information to this address.
Emergency Contact: Please do not fill this out if you do not want us to contact this person.
Referral: If you are filling this form out for yourself, please leave this section blank.

B. CASE MANAGEMENT

This section is to be completed by your Ryan White Case Manager (Part B). If your income is at or below the federal poverty level, you are required to have a Ryan White Case Manager.

C. PUBLIC ASSISTANCE

In this section, please indicate all public assistance programs for which you have applied (left side) and those you are receiving (right side). If you have NOT applied for any of the listed public assistance programs, please check the box at the bottom indicating that you have not applied and please let us know why (for example, "I work fulltime").

Please provide copies of Medicaid and Medicare Approvals/Denials or letters indicating that your case is pending when you submit your application.

D. HOUSEHOLD INCOME INFORMATION

In this section, please indicate all the people who live in your house with you. Tell us their ages and relationship to you. If you have a spouse or children not living with you but who impact your income (for example, you pay or receive child support), please list these people as well and indicate that they do NOT live at the same address.

Please provide copies of your proof of income documents and a copy of your IRS tax transcript for the last tax year. Please submit three years of tax transcripts in addition to income documents if you are self-employed. If you are married, we also need proof of income documents and IRS tax transcripts for your spouse. Information for requesting your tax transcript is included on page 3 of these instructions.

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. If you have no insurance, please check the box that says "I don't have any health insurance coverage."*

*In order to assist you with paying premiums for your insurance and/or co-pays for your prescriptions, you must provide us with **all** of the information requested or we will not be able to assist you.*

You must provide a legible copy of your insurance card (front and back) with this application.

F. PRESCRIPTION COVERAGE

You must provide a legible copy of your prescription card (front and back) with this application (if your prescription card is separate from your insurance card).

INDIVIDUAL AUTHORIZATION FORM

INDIVIDUAL'S INFORMATION

Include information about the individual whose information will be released.

The form with the above heading (page 6) is required for all applicants who have insurance. This is a HIPAA release that allows us to talk with your insurance company. Please read the release, add the necessary information and sign it only if you understand it

If you don't have insurance, please do not fill out this form.

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

This form is a release that describes the circumstances where we can share your information with others and it is good for two years after you sign it. You may also revoke it in writing at any time. Please read the release and sign and date it only if you understand it.

Physician Verification Form

Your doctor's office needs to complete this form. In addition, your doctor needs to provide us with a list of the medications you are currently taking. We have provided a convenient checklist to help your doctor. The Verification Form and the Medication List must be submitted with your OHDAP application.

If you have any questions about how to apply for OHDAP programs, how to complete this application, or any other concern or consideration, please don't hesitate to call us at 1-800-777-4775. This is a toll free number.

If you want to fax your application to us, our secure fax number is 1-866-448-6337. This is a toll free number.

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
☐ Formulary ☐ Single Drug (specify): _____ ☐ Co-Pays (for Private Health Insurance) ☐ Co-Pays (for Medicaid) ☐ Co-Pays (for Medicare)	☐ Private Health Insurance Premiums ☐ COBRA Policy Premiums ☐ Medicare Part D Policy Premiums	☐ Monthly Spenddown ☐ Emergency Spenddown *For those who also have Medicare, a rationale for monthly spenddown payments must be provided.*
*In order to qualify for any type of co-pay or premium assistance, **complete** insurance information must be provided.* ***Application can not be processed without this information**.*		

A. DEMOGRAPHIC INFORMATION

Application Date: __ __| __ __ | 2 0 __ __

Social Security No: __ __ __ - __ __ - __ __ __ __

First Name Middle Name Last Name ☐ Junior ☐ Senior

Address: Apt. ☐ (check if new address since last application)

City: State: OHIO

ZIP: County:

Home Phone: ( ) –

Work Phone: ( ) –

May we leave a message? ☐ Yes ☐ No

May we call you at work? ☐ Yes ☐ No

Cell Phone: ( ) -

May we leave a message? ☐ Yes ☐ No

Email Address (include only if we can contact you via email):

Emergency Contact* Name and Phone (__ __ __) __ __ __– __ __ __ __

Relationship: **This must be someone we can contact!*

Sex	Ethnicity	Race (Please check all that apply)
☐ Male	☐ Hispanic/Latino	☐ Amer. Indian or Alaska Native
☐ Female	☐ Non Hispanic/Latino	☐ Asian
☐ Transgender		☐ Black or African American
		☐ Native Hawaiian or Other Pacific Islander
		☐ 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:
☐ MAI
☐ 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)	☐ 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 Application Date: _____ ☐ Part B Application Date: _____ ☐ Part D Application Date: _____ (Dates are not necessary if you are receiving Medicare)	☐ Medicare ☐ Part A ☐ Part B ☐ Part D
☐ Social Security Disability Income (SSDI) ☐ Supplemental Security Income (SSI)	☐ Social Security Disability Income (SSDI) ☐ Supplemental Security Income (SSI)
☐ Veteran's Benefits	☐ Veteran's Benefits

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

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]	$	$
	If you report income at or below the federal poverty level, please sign a "Verification of Income Statement" with your case manager.	

Employment Status (Check all that apply):

- ☐ Full-time (40 or more hours per week)
- ☐ Part-time
- ☐ Self Employed
- ☐ Unemployed
- ☐ Medically Disabled
- ☐ *Retired*

I am paid every:

- ☐ Week
- ☐ Two (2) Weeks
- ☐ Month
- ☐ Other

Marital Status:

- ☐ Single
- ☐ Married
- ☐ Legally Separated
- ☐ Divorced
- ☐ Widowed

CLIENT	**One of the following**: ☐ Copies of paychecks (4 recent consecutive weeks within last 45 days—for all applicants who work) ☐ Social Security Benefit/Award letter ☐ Other (specify):	**AND**	☐ 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**: ☐ Copies of paychecks (4 recent consecutive weeks within last 45 days—for all spouses who work) ☐ Social Security Benefit/Award letter ☐ Other (specify):	**AND**	☐ 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.

I have health insurance coverage through:

- ☐ Private Insurance Policy
- ☐ COBRA *(If checked, see box at right)*
- ☐ Medicare
- ☐ Medicaid
- ☐ Other
- ☐ I don't have any health insurance coverage *(Continue application with the Authorization for Proof and Release of Information section)*

If you have a COBRA Policy, please complete information below:

COBRA Start Date: _____

COBRA End Date: _____

☐ Attach copy of your COBRA election form.

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
☐ Prescriptions (if yes, complete Prescription Coverage Section below)	$
☐ Dental	$
☐ Vision	$
☐ 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
☐ I must pay for _____% of my prescription medications.	☐ I have a co-payment of $_____ per each PREFERRED Brand Named Drug
☐ I must pay 100% up front and wait for reimbursement of _____%. [**Non-Assignable**]	I have a co-payment of $_____ per each Brand Named Drug
	☐ I have a co-payment of $_____ per each generic Drug
☐ I have a limit on prescription coverage of $_____ per ☐ month ☐ year	

Please include <u>clear</u> photocopy of front and back of insurance card <u>AND</u> 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.

_____ Date: _____
Signature of insured adult, parent/guardian of minor insured

_____ Date: _____
Signature of legal representative of insured (if applicable)

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]

ADDITIONAL INFORMATION

Use the section below to provide any additional information you think might clarify or explain any part of the attached application (e.g., rationale for monthly SD payment, etc.)

Add additional pages as necessary.

APPLICATION CHECKLIST

For All Applications

- ☐ All sections of the application are complete and legible.
- ☐ Signed Physician Verification Form and Med List are attached (lab values not older than 6 months)
- ☐ Proof(s) of Income information provided
- ☐ IRS Tax Transcript for most recent tax year provided for all individuals who work AND THEIR SPOUSES (Three years of tax transcripts are required for self employed individuals).
- ☐ Verification of Income Statement Included

For Applicants with Limited Income	For Applicants who want Assistance with Insurance Premiums and Co-Payments
☐ Case Manager has signed the application (required for all applicants at or below 100% of the Federal Poverty Level) ☐ Proof of application for Medicaid/Medicare	**No assistance with premiums or insurance co-payments can be made without the following:** ☐ Insurance Payment Section of Application is complete ☐ Signed HIPAA Release provided for ANY client with insurance coverage ☐ Legible copy (front and back) of health insurance card (including Medicare). ☐ COBRA election form (if applicable)

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

	RESULT		Date of most recent test [MM/DD/YYYY] Must be within the last 6 months
Test Type	**Percentage**	**Absolute Value**	
CD 4 Count			☐☐ - ☐☐ - ☐☐☐☐
Viral Load			☐☐ - ☐☐ - ☐☐☐☐

☐ 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?	☐ Yes ☐ No
2. Is patient receiving any medications through Clinical Trials?	☐ Yes ☐ No
3. Are you prescribing HIV medication (HAART) for this patient?	☐ Yes ☐ No

HIV Disease Staging	**Level of Care**
Please check the appropriate box for this patient's <u>lowest</u> historic lab results: ☐ Stage 1 (CD4+ >500) ☐ Stage 2 (CD4+ <500 and >200) ☐ Stage 3 (CD4+ <200) ☐ Stage 4 (For use only for a client who has recently tested positive and for whom no CD4/viral load information is available.)	*Please check the appropriate box*: ☐ Well Generally ☐ Intermittently ill, but able to perform activities of daily living ☐ Intermittently ill, requires assistance with some (1-3) activities but generally able to care for self ☐ Requires assistance with 3 or more activities of daily living and/or personal care ☐ Unable to care for self and/or is bedridden ☐ 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)

VERIFICATION OF INCOME STATEMENT
FOR ALL APPLICANTS

I _____ (print applicant name) swear or affirm that I currently do not receive income of any type that has not already been reported in my application for the OHIO HIV Drug Assistance Program (OHDAP). I understand that income includes all money received from work, even that which is not reported for tax purposes. Income also includes, but is not limited to, money received from retirement, investments, unemployment compensation, and disability benefits. I am aware that I must also report any and all income earned by a married spouse (if married) and parents (if a dependent).

I am aware that providing false, incomplete or inaccurate information regarding income or any other aspect of the Ohio HIV Drug Assistance Program (OHDAP) application may result in my inability to receive further assistance from any and all Ryan White Care Act funded programs.

_____
Applicant Signature

_____
Date (mm/dd/yyyy)

To help avoid treatment delays, please fax this form PROMPTLY along with a fully completed OHDAP Application to:

Ohio Department of Health/HIV Care Services Section
246 N. High Street, 6th Floor
Columbus, OH 43216-0118
800-777-4775 (Phone)
866-448-6337 (Fax)