2021

Georgia Ryan White Part B, AIDS Drug Assistance Program (ADAP), and Health Insurance Continuation Program (HICP) Policies & Procedures

Georgia Department of Public Health, Division of Medical and Clinical Program Services, Office of HIV/AIDS

Contents

Introduction

About this Document

The Georgia Ryan White Part B/ADAP/HICP Policies and Procedures Manual provides guidance on the Ryan White Part B, the AIDS Drug Assistance Program (ADAP), and the Health Insurance Continuation Program (HICP), and defines the administrative functions and processes in Georgia. This manual provides an overview of the Ryan White CARE Act and its various revisions with a detailed description of the most recent law implemented. A discussion follows of Georgia's Ryan White Part B Program with specific focus on its components. Included in this manual are also lists of Georgia Ryan White Part B Clinics and ADAP/HICP Enrollment sites. The manual is a living document to be updated as needed. All information, policies, procedures and documents found herein are effective as of April 1, 2021.

Ryan White Overview

The Ryan White Comprehensive AIDS Resources Emergency Act is a Federal legislation that addresses the unmet health needs of persons living with HIV/AIDS (PLWHA) by funding primary health care and support services that enhance access to and retention in care. First enacted by Congress in 1990, it was amended and reauthorized in 1996, 2000, 2006 and 2009; it was funded at $2.4 billion in 2021.

The Ryan White HIV/AIDS Treatment Modernization Extension Act of 2009

Federal funds are awarded to agencies located around the country, which in turn deliver care to eligible individuals under funding categories called Parts.

- **Part A** provides emergency assistance to Eligible Metropolitan Areas and Transitional Grant Areas that are most severely affected by the HIV/AIDS epidemic.
- **Part B** provides grants to all 50 States, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and five (5) U.S. Pacific Territories or Associated Jurisdictions.
- **Part C** provides comprehensive primary health care in an outpatient setting for people living with HIV disease.
- **Part D** provides family-centered care involving outpatient or ambulatory care for women, infants, children, and youth with HIV/AIDS.
- **Part F** provides funds for a variety of programs:
    - **The Special Projects of National Significance Program** grants fund innovative models of care and supports the development of effective delivery systems for HIV care.
    - **The AIDS Education and Training Centers Program** supports a network of eight regional centers and several National centers that conduct targeted, multidisciplinary education and training programs for health care providers treating people living with HIV/AIDS.
    - **Dental Programs** provide additional funding for oral health care for people with HIV.

Georgia Ryan White Part B Components

Below is a description of the Georgia Ryan White Part B Program and its components.

Ryan White Part B Program

In Georgia, the Ryan White Part B Program is administered by the Georgia Department of Public Health (DPH), Division of Health Protection, Office of HIV/AIDS. The Office of HIV/AIDS funds agencies in 16 public health districts to deliver HIV/AIDS services throughout the state. The agencies are responsible for planning and prioritizing the delivery of HIV services in their respective geographic areas. All funded agencies provide primary care services. Support services are funded based on the availability of resources. Part B also funds the Georgia ADAP and HICP, which provide medications and health insurance coverage. Please see **Appendix A** for a list of the Part B Primary Care Clinics.

Seventy-five percent of Part B funds must be used to fund "core medical services" which include outpatient and ambulatory health services; ADAP; AIDS pharmaceutical assistance; oral health care; early intervention services; health insurance premium and cost-sharing assistance; home health care; medical nutrition therapy; hospice care; community based health services; substance abuse outpatient care; and medical case management, including treatment adherence services. The remaining 25 percent of funds must go to support services that are needed for PLWHA to achieve their medical outcomes, such as respite care, outreach services, medical transportation, linguistic services, and referrals for health care and support services. Please refer to HRSA PCN #16-02 for definitions for each of the above HIV services.

ADAP

ADAPs are state administered programs that provide HIV/AIDS medications to low-income individuals living with HIV disease, who have little or no coverage from private or third-party insurance. Georgia ADAP services are available to all eligible residents throughout all 18 health districts in the state. There are 26 enrollment sites (**Appendix B**) in Georgia, inclusive of seven (7) approved sites located in metro Atlanta.

HICP

The Georgia HICP is a state administered program which assists eligible persons who are unable to pay their health insurance premiums for private/individual or Consolidated Omnibus Budget Reconciliation Act (COBRA) plans. This special program pays a maximum monthly health insurance premium of $1,788.00, which may include a spouse and children on a family health insurance plan, as well as dental and vision. The HICP also covers medication co-pays, in addition to premiums, for eligible individuals. The program will only accept new clients who have insurance plans that include both outpatient primary care coverage and prescription coverage without a yearly cap. The HICP allows clients the opportunity and flexibility to continue to access their doctors, maintain a continuum of primary health care and sustain an improved quality of life. In addition, the program offers prescription co-pay assistance to eligible Medicare Part D participants. The Medicare Part D co-pay assistance component of the program will assist individuals with out-of-pocket costs for ADAP approved formulary medications.

The Office of HIV/AIDS has continued to evaluate the effectiveness of the HICP, which pays health insurance premiums and medication co-pays for eligible clients with health coverage. The provision of health insurance assistance has proven to be a more cost-effective way to meet the needs of clients in

comparison to providing expensive HIV/AIDS medications at a much higher cost. Georgia HICP services are available to all eligible residents of Georgia at all ADAP-HICP enrollment sites (**Appendix B**).

Hepatitis C Program

The Georgia Hepatitis C Program is a state administered program that assists eligible ADAP/HICP participants living with Hepatitis C obtain medications covered on the Georgia ADAP formulary. The program will provide the medications for the entire course of treatment at one (1) ADAP Contract Pharmacy of the participant's choice. The Georgia Ryan White Part B/ADAP program will approve only one (1) complete Hepatitis C regimen for each program participant. **Georgia Hepatitis C services are currently on hold due to funding constraints**, but when funding becomes available, active ADAP/HICP participants and must apply for Hepatitis C services through their local ADAP-HICP enrollment site.

Minority AIDS Initiative (MAI)

The Georgia Ryan White Part B Program utilizes MAI funds for the implementation and continuation of the evidence-based Antiretroviral Treatment and Access to Services (ARTAS) Linkage Case Management intervention to conduct outreach, educate and link minority clients into care, ADAP, partner services, and other social services. Ryan White MAI funded health agencies use ARTAS as a method to identify and re-engage clients who have been "lost to care" and re-link them.

Emerging Communities (EC)

Georgia has one eligible emerging community, the Augusta-Richmond County, GA-SC metropolitan statistical area (MSA), part of the Augusta Health District. The Augusta-Richmond County, GA-SC MSA includes the Richmond, Burke, Columbia, Lincoln, and McDuffie counties in Georgia and Aiken and Edgefield counties in South Carolina. ECs are determined based on cumulative AIDS cases reported to and confirmed by the CDC during the most recent period of five calendar years. EC funds are used to provide increased access to unfunded or underfunded services.

Section 1: Sub-Recipient Roles & Responsibilities

The primary role of sub-recipients, also referred to as funded agencies, is to provide medical and support services to all eligible PLWHA who reside in Georgia. Sub-recipients are responsible for maintaining appropriate relationships with entities in the area they serve that constitute key points of access to the health care system for individuals with HIV/AIDS (emergency rooms, substance abuse treatment programs, detoxification centers, adult and juvenile detention facilities, STD clinics, and others) for the purpose of facilitating early intervention for individuals newly diagnosed with HIV/AIDS and individuals knowledgeable of their HIV status but not in care. **Services provided must meet all service standards set forth by the state**, and must align with HRSA's Ryan White Universal and Part B programmatic and fiscal National Monitoring Standards.

HIV Care Continuum

The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the HIV Care Continuum or the HIV Treatment Cascade. The HIV Care Continuum includes the diagnosis of HIV, linkage to HIV medical care, lifelong retention in HIV medical care, appropriate prescription of antiretroviral therapy (ART), and ultimately HIV viral load suppression.

Sub-recipients are encouraged to assess the outcomes of their programs along the HIV Care Continuum. Collaboration with community and public health partners to improve outcomes across the Continuum is key, so that individuals diagnosed with HIV are linked and engaged in care and started on ART as early as possible. Performance measures developed for the Ryan White Part B Program should be used to assess the efficacy of the programs and to analyze and improve the gaps along the Continuum.

Care Consortium

Sub-recipients must collaborate with their local Ryan White Part B HIV Care Consortia to conduct appropriate assessments of need, prioritizing and planning for the delivery of allowable Ryan White Part B medical and support services. Delivery of HIV medical and support services shall be provided either directly by the sub-recipient or indirectly through sub-contractual agreements with outpatient, home health care and support service providers. Each Ryan White Part B HIV Care Consortia should have written bylaws and procedures for membership in place. Consortia meetings should be conducted no less than quarterly. Minutes from each meeting shall be sent to the assigned District Liaison.

Sub-recipients are responsible for completing a yearly needs assessment through their Ryan White Part B Care Consortia in order to gain community input that can assist in prioritizing and ranking service needs. Each sub-recipient must submit documentation of the current needs-assessment to the assigned District Liaison. Information about the needs-assessment is also required for the Ryan White Part B HIV Care Application.

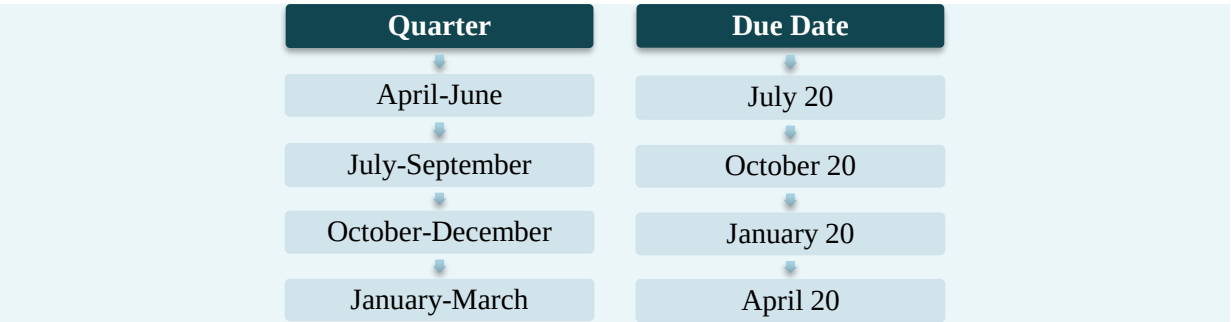
Programmatic Expectations

Each sub-recipient and sub-contractor is contractually required to be compliant with the audit requirements in 45 CFR 75 Subpart F. Sub-recipients must also comply with the requirements listed in the Georgia DPH Annexes through which they receive funding for Ryan White, or applicable contract, as well as those expectations delineated in this manual.

Sub-recipients are required to submit programmatic/quality reports, expenditure reports, and implementation plans, as well as utilize CAREWare to collect and report data and/or fiscal reports as necessary for all Part B Program funds. These reports are utilized for both programmatic and fiscal monitoring purposes to report on the progress of goals and objectives as well as identify challenges, barriers, and technical assistance needs. Report templates can be found with the yearly annexes and by contacting your assigned District Liaison. Sub-recipients are also responsible for submitting a Ryan White Part B HIV Care annual report and application when required.

As part of their quarterly responsibilities, sub-recipients are responsible for submitting a Quarterly Expenditure Report, Quarterly Implementation Plan, and the Quarterly Quality Management (QM) Report. The reports are due no later than the 20th day of the month following the end of the quarter (**Figure 1**) and must be submitted in the format provided by the state.

Figure 1. Reporting Dates



Before engaging in a sub-contractual process, sub-recipients must submit a justification as to why they have a need to sub-contract services, as well as a copy of the drafted contract for approval by the Office of HIV/AIDS Ryan White Part B Program **before execution of the sub-contract**. The justification is to verify that any sub-contracts paid for with Ryan White Part B funding are compliant with Ryan White regulations and guidelines. All contracts must be fully executed and signed prior to the provision of services. Reimbursements must be based on services provided and invoices must include an appropriate description of services. Flat rate reimbursement schedules are **not** permitted. Sub-recipients are responsible for verifying and documenting that any sub-contractors providing services to clients have appropriate credentials, licensure and liability coverage. **Sub-recipients are required to conduct at least one on-site monitoring visit to all sub-contractors annually to assess the sub-contractors' compliance with state and federal regulations, including HRSA Ryan White Universal and Part B programmatic and fiscal National Monitoring Standards.** On-site monitoring reports and corrective action plans are submitted when indicated. **A list of all sub-contractors and copies of all sub-contracts must be submitted to the state office on a yearly basis. These documents will also be reviewed by Georgia DPH auditors.**

Sub-recipients must submit a line-item budget using the form provided by the Office of HIV/AIDS Ryan White Part B Program. Unless otherwise directed, budgets are to be completed for the upcoming year using the same level of funding awarded the previous year. A narrative budget justification must accompany the budget form. The total amount of Administrative Costs and Indirect Costs paid with Ryan White Part B funds shall not exceed 10% of the total allocation. Personnel costs for direct service contractors, such as clinicians, case managers, etc., are not considered administrative and must be indicated under direct care costs.

The budget total cannot be exceeded. However, a plus or minus deviation of 10% within budget line items is authorized. **In the event that expenditures for a line item are expected to exceed these limits, a budget revision must be submitted and approved by the Office of HIV/AIDS in advance.** A maximum of two (2) budget revisions are allowed in a single fiscal year. Requests for an exemption due to extenuating circumstances (e.g., unprecedented changes in staffing) must be submitted to the Office of HIV/AIDS for review and approval.

If 75% of funds are not expensed by the end of December, the sub-recipient is required to submit a written report illustrating how the remaining funds will be spent or if the funds cannot be spent. If this occurs, the Office of HIV/AIDS Ryan White Part B Program reserves the right to unallocate funds anticipated to lapse

and reallocate those funds to another sub-recipient. Such reallocations will be a one-time allotment and will not be reoccurring funds for the succeeding fiscal year.

***NOTE 1**: Indirect costs taken out of Ryan White Part B funding are considered administrative and must fall within the 10% administrative cap.* ***No indirect costs are to be charged to MAI or Emerging Community (EC) funds**.*

***NOTE 2**: Please refer to HRSA Policy Clarification Notice (PCN) #15-01 for additional details regarding the 10% administrative cap.*

At a minimum of once a year, sub-recipients shall participate in a performance review (administrative site visit) of the Part B Program to be conducted by the Office of HIV/AIDS District Liaison and other staff as needed. Minimum requirements for site visits will be contingent on staffing and travel restrictions. Upon completion of the performance review, a summary of findings will be sent to the HIV Coordinator and Health Director. If the Office of HIV/AIDS Ryan White Part B Program recommends corrective action, the sub-recipient is expected to complete and submit an action plan that includes key actions and time frames to improve program performance for those areas identified. Upon receipt of the final administrative report, the sub-recipient will have **45 days** to submit their corrective action plan to the Office of HIV/AIDS. If corrective action measures are not implemented within the specified timeframe, funding may be restricted.

Imposition of Charges

Sub-recipients shall implement an imposition of charges policy. If reimbursement for primary care and support services from any third-party payer (such as private insurance or Medicaid) is accepted, clients provided services under this agreement must be assessed for fees for services provided, according to a sliding fee schedule and in accordance with federal requirements outlined in the Ryan White CARE Act of 1990, as amended. Only clients whose incomes exceed 100% of the current FPL are to be assessed fees for Ryan White Part B services.

Program Income

Program income is gross income earned that is directly generated by a supported activity or earned as a result of the Federal award during the period of performance (the Part B period of performance is from April to March). Examples of program income include:

- Charges imposed on clients for services;
- Funds received by billing public or private health insurance for services provided to eligible clients;
- Fees, payments, or reimbursement for the provision of a specific service, such as patient care reimbursements received under Medicare, Medicaid, or Children's Health Insurance Program;
- The difference between the third-party reimbursement and the 340B drug purchase price.

Program income must be used for activities related to Ryan White Part B care services; including core medical and support services, clinical quality management, and/or administrative expenses (including planning and evaluation). Sub-recipients should retain program income for use within their own Ryan White Part B programs but must report program income earned through Part B and how they plan to use the funds to the state. While program income must be used for allowable services under Part B, income can be used to expand the services provided outside of what is approved in the sub-recipient Part B budget.

***NOTE 1**: Program income is not subject to the 10% administrative cap in order to support a comprehensive system of care.*

***NOTE 2**: For additional information on program income refer to HRSA PCN #15-03.*

Recertification

Ryan White Part B service providers should review client eligibility at every visit. **All Ryan White Part B, ADAP and HICP clients are required to recertify every six months.** Clients will be able to self-attest during one of their yearly recertification periods **but** must submit all appropriate documentation during their 12-month recertification period. Clients need to be screened for other payer sources and income to ensure program eligibility and compliance with "payer of last resort" regulations. In order to verify that Ryan White is the "payer of last resort" Ryan White clinics must collect and maintain client documentation regarding client eligibility for other health plans or lack thereof. Please see the Eligibility Recertification section for additional details. The local ADAP Coordinator or case manager should initiate the recertification process during a face-to-face interview.

Stop Gap Medications

The Stop Gap Medication program is available depending on Ryan White Part B funding and is currently on hold. Stop Gap Medication funding provides sub-recipients with the resources to purchase medications on the ADAP formulary (antiretroviral and non-antiretroviral (OI) medications) for use while clients are waiting on ADAP approval/recertification.

As Ryan White is considered the "payer of last resort," stop gap medications are not to be used until all other resources have been exhausted. Before utilizing stop gap medications, sub-recipients should verify that ADAP applications/recertifications are submitted completely and in a timely manner to allow for processing and approval without resulting in a gap in services. In addition, sub-recipients should reach out to patient assistance programs (PAPs) whenever possible before utilizing stop gap medications. Steps taken before medications are prescribed must be documented to show that stop gap funding is being utilized appropriately.

If available resources are limited, provision of stop gap medications should be prioritized for Ryan White Part B eligible clients with the following conditions:

- Pregnancy
- CD_4 count below 200 cells/mm^3
- History of an AIDS defining illness
- Co-morbid conditions (e.g. HIV-associated dementia, HIV-associated nephropathy, Hepatitis B virus co-infection)
- Acute HIV infection

Stop Gap Medications **cannot** be utilized for individuals who do not qualify for Ryan White Part B services, as a long-term solution to treating clients, or to purchase medications in bulk. Any credits from expired medications from past purchases with state funding must be reported to the Georgia Ryan White Part B Program through the assigned District Liaison.

If a sub-recipient has a need to purchase stop gap medications, a staff member will need to complete the Justification for Order of Stop Gap Medications worksheet (**Appendix C**) and submit to the state office through the assigned District Liaison for approval before any medications are ordered from Cardinal or any invoices are submitted to the state. If approval is granted based on the justification, the sub-recipient may then place an order for the medications and the invoice can be submitted to the state office for payment. Sub-recipients approved for the purchase of medications must continue to submit a monthly copy of the Medication Dispending Log (**Appendix D**), utilizing the CAREWare URN as the client identifier and matching the information reported in the justification. This log must be submitted to the Office of HIV/AIDS on the 3rd of each month.

MAI Funding

Sub-recipients receiving MAI funding for the implementation and continuation of ARTAS Linkage Case Management must utilize funds to coordinate linkage efforts in order to maximize education and outreach strategies to link minorities to ADAP and reduce duplication of services and efforts. The focus of the initiative is to target those minorities who know their HIV status and have not accessed care within 6-12 months, and effectively link these clients to medical care (specifically, medication services including ADAP) within 30 days. Funding can only be used for two service categories, outreach and health education.

In addition to the quarterly expenditure reports and implementation plans, sub-recipients receiving MAI funding are required to utilized CAREWare for data collection and reporting and submit **monthly data reports** which are **due by the 15th of each month**. As part of the collaborative efforts with the HIV Prevention Program, sub-recipients are also expected to participate in combined linkage efforts and ARTAS technical assistance calls.

Table 1. Reports and other Programmatic Documents Required

Report	Supporting Documentation	Due Date
Fiscal Year (FY) Budget	N/A	Due April 25th of the new FY. Will need to be resubmitted as changes are made to the budget during the FY.
FY Budget Narrative	N/A	Due April 25th of the new FY. Will need to be resubmitted as changes are made to the budget during the FY.
Funding Document	N/A	Due April 25th of the new FY.
FY Implementation Plan	N/A	Due April 25th of the new FY. Will need to be resubmitted as changes are made to the budget during the FY.
Budget Revision	Updated budget, budget narrative, and FY implementation plan.	No specified date, up to two per grant year.
Subcontractor List	Copies of contracts and deliverables.	June 30
Consortium Agreements and Assurances	N/A	June 30
Expenditure Report	N/A	Due quarterly (*refer to Figure 1 for dates*)
Quarterly Implementation Plan (*includes numbers and expenses for quarter of submission*)	N/A	Due quarterly (*refer to Figure 1 for dates*)

Report	Supporting Documentation	Due Date
Programmatic/Quality Report	QM meeting minutes, updated QM Plan	Due quarterly (*refer to Figure 1 for dates*)
MAI Data Reports (*only applies to those districts funded for MAI*)	N/A	Due the 15th of each month
Ryan White Part B HIV Care Consortia application	Refer to grant application package.	Determined by the Office of HIV/AIDS, contingent upon receipt of the HRSA Part B Grant Application Guidance to State

Clinical Quality Management (CQM) Expectations

Sub-recipients, also referred to as funded agencies, are expected to refer to the Georgia Ryan White Part B CQM Plan which contains goals, objectives and strategies to ensure implementation and monitoring of CQM activities, as well as compliance with HRSA's CQM expectations at both state and local levels. Ryan White Part B CQM Program activities are delineated in the plan, including capacity building and providing quality-related technical assistance to subrecipients. The Ryan White Part B CQM Core Team provides oversight and facilitation of the plan and is composed of multidisciplinary professionals within the Office of HIV/AIDS. In addition, the statewide Ryan White Part B CQM Core Team Committee includes representation from all subrecipients, additional Office of HIV/AIDS staff, Ryan White Parts A, C, D, F and consumers.

Quality and Programmatic Compliance

Sub-recipients are expected to comply with the following requirements:

- Ensure that medical management of HIV infection is in accordance with the United States Department of Health and Human Services (DHHS) HIV-related guidelines. Compliance with DHHS HIV-related guidelines is a requirement of the Health Resources and Service Administration (HRSA) for sites receiving Ryan White HIV/AIDS Treatment Extension Act funding. The DHHS guidelines are considered "living" documents and are available online at HIVinfo.NIH.gov, website https://hivinfo.nih.gov/.
- Ensure compliance with the Georgia Department of Public Health (DPH), Office of HIV/AIDS, Ryan White Part B Clinic Personnel Guidelines (current edition).
- Ensure that registered professional nurses (RNs), advanced practice registered nurses (APRNs), and physician assistants (PAs) practice under current HIV/AIDS-related nurse and PA protocols. The recommended protocols and/or resources include the following as applicable:
    - Georgia Department of Public Health, Office of Nursing, Standard Nurse Protocols for Registered Professional Nurses in Public Health, Adult with HIV (current edition).
    - Georgia Department of Public Health, Prescriptive Authority for Advanced Practice Registered Nurses Toolkit (current edition).
    - Georgia Department of Public Health Policy #PT-18001, Georgia ADAP and APRN Prescriptive Authority for Nurses Not Employed by Public Health Policy and Procedure (current edition).
    - Georgia Department of Public Health Policy #PT-18002, Georgia AIDS Drug Assistance Program Physician Assistant Provider Status Policy and Procedure (current edition).
- Ensure that all physicians, pharmacists, and all other licensed medical professionals possess current licensure and/or certification.

- Ensure that all physicians are practicing under current HIV/AIDS-related protocols and are practicing under the current laws of the State of Georgia. If there is any lapse in licensure and/or the occurrence of suspension that deems a medical professional unable to practice medicine under current laws, the Office of HIV/AIDS's District Liaison is to be notified immediately.
- Develop and implement a CQM Program according to HRSA's HIV/AIDS Bureau (HAB) expectations for Ryan White recipients, to include the following:
    - A leader and team to oversee the CQM Program
    - CQM goals, objectives and strategies
    - A written CQM Plan, updated annually and Work Plan, updated quarterly
    - Continuous Quality Improvement (CQI) projects that incorporate Quality Improvement (QI) methodologies to address performance measures below state goals, updated quarterly
    - Performance measures and mechanisms to collect data
    - Communication of results to all levels of the organization, including consumers as appropriate
- Participate in the statewide Ryan White Part B CQM Program, including but not limited to a designated representative and attendance in CQM Core Team Committee meetings.
- Monitor performance measures as determined by the Georgia Ryan White Part B CQM Program.
- Participate in HIV clinical and case management chart reviews conducted by state office CQM staff.
- Provide CQM Plans, reports (including CQI activities), and other information related to the subrecipient CQM Program as requested by the Office of HIV/AIDS Ryan White Part B District Liaison and/or CQM staff. Allow the District Liaison and/or CQM staff access to all CQM information and documentation.
- Ensure compliance with the Georgia Ryan White Case Management Standard Operating Procedures (current edition).

Section 2: Program Monitoring and Oversight

The Georgia Office of HIV/AIDS Director, Ryan White Part B Program Manager, Assistant Manager, District Liaisons, ADAP Program Manager and Fiscal Analyst are responsible for all fiscal and programmatic monitoring of the Part B program. The following is a description of the overall program and fiscal monitoring policy and activities.

Budget Review and Reporting

At the beginning of each contract period, and annually thereafter, sub-recipients develop budgets based on local prioritization of needs and in accordance with Ryan White guidelines. Budgets are submitted to the Office of HIV/AIDS for review, revision and approval. Sub-recipients are contractually obligated to submit fiscal reports on a quarterly, bi-annual and annual basis. Sub-recipients receive fiscal reports from subcontractors on a monthly basis as relevant. Programmatic reports are submitted by all sub-recipients at mid-year of the grant period, year end of the grant period, calendar year and as required by HRSA. Sub-recipients are required to report client-level data annually directly to the HIV/AIDS Bureau (HAB) through the Ryan White HIV/AIDS Program Services Report (RSR). It is a requirement that all sub-recipients use CAREWare for managing and monitoring HIV clinical and supportive care and producing the RSR.

Eligible Service Categories

All Ryan White eligible services as defined by HRSA are eligible for reimbursement through the Georgia Ryan White Part B program. Based on a review of the current service delivery system and the variances in the care systems in each locality, Georgia allows sub-recipients to provide the full array of eligible services as determined on a local level. Services are budgeted and approved at the beginning of each grant year. For a list of allowable services and definitions refer to HRSA PCN #16-02.

NOTE: *Pertaining to laboratory costs under Outpatient/Ambulatory Care - Sub-recipients are expected to utilize the state lab for services paid for by the State Office (e.g. HIV viral loads). Ordering the labs mentioned through the state lab is a cost saving measure to the sub-recipients as state lab costs do not come from assigned budgets but are covered by the Office of HIV/AIDS Ryan White Part B Program. Tests not covered under the state lab contract can be paid for by grant funds as long as they are related to the standards of care for Ryan White clients. Every effort should be made to obtain Ryan White pricing from contracted labs in order to minimize lab costs and allow for more expanded client services through cost savings.*

Invoice Review

All sub-recipients are required to submit invoices in a standardized format (by service category as opposed to operating category). Once invoices are submitted to the Department of Public Health (DPH) they are subject to two levels of review. The District Liaison is the first level of review. The invoices and reports are reviewed to ensure compliance with contract deliverables. If questions should arise on services provided, the sub-recipient is contacted for additional information. Once reviewed, the invoices are submitted for final review to Accounts Payable for payment to be rendered to the sub-recipient.

Programmatic and Fiscal Monitoring

All 16 Part B sub-recipients receive administrative, fiscal, and programmatic monitoring via monthly desk audits and annual on-site monitoring.

Administrative site visits are conducted annually to monitor compliance with state and federal regulations, including HRSA Ryan White Universal and Part B programmatic and fiscal National Monitoring Standards. Examples of documentation reviewed include the following:

- Client eligibility and recertification documentation
- Fee-for-service (clients with incomes exceeding 100% of the current Federal Poverty Level)
- Programmatic report documentation
- Expenditure report documentation
- Documentation of providers' Medicaid certification
- Mechanisms to bill third party payers
- Client rights and responsibilities available in English and Spanish, and updated/signed annually
- Security and confidentiality
- Linkages to external providers
- Grievance policies available in English and Spanish, and updated/signed annually

MAI site visits are conducted concurrently with Part B and Emerging Community visits and include: a review of the MAI budget and expenditures to date, review of demographics for clients served, outreach and education processes, monitoring and chart review assessments. Upon completion of local programmatic

site visits, District Liaisons complete site visit reports that include summary narratives; monitoring and chart review assessments; and, if necessary, request corrective action plans. If a local program is placed on a corrective action plan, District Liaisons follow-up within **45 days** to discuss the plan of action and timeline for corrective measures to ensure compliance with the Ryan White HIV/AIDS Treatment Extension Act of 2009. All findings and reports are shared with the local Part B Coordinator and District Health Director and documented in the sub-recipient's file.

Pharmacy Monitoring Process

Initial pharmacy site visits are conducted to provide technical assistance for compliance with contractual guidelines. Pharmacy site audits are conducted to review and determine compliance with the ADAP Contract Pharmacy (ACP) Network contract deliverables and 340B federal requirements. Additionally, the audits serve as a venue to provide guidance, and identify training opportunities and areas for quality improvement. Presently, the ACP Network replenishment process is monitored daily via automated reports from the pharmaceutical wholesaler. The current Pharmacy Benefit Manager (PBM) is utilized to audit contract pharmacies 340B inventory, via dispensing, order history, and order balance reports. In addition, 340B and 340B prime vendor prices are reviewed quarterly.

ADAP

Monthly desk audits are performed to monitor ADAP client utilization including attrition patterns, clients served and adherence data from CAREWare and the PBM. ACP monitoring reports are reviewed and obtained from the PBM portal. The PBM submits monthly invoices indicating utilization, number of clients served, dispensing fees, administrative fees, and the number of prescriptions adjudicated. Additional reports contain data outlining comprehensive activities of all pharmacies, including date and time of medications dispensed. Custom reports outlining trends in claims adjudication and dispensing may also be requested from the PBM. Data obtained from routine and custom reports have proven to be a viable forecasting tool for fiscal and programmatic projections. Monthly QM monitoring includes a review of data to determine the percentage of clients recertified every six months, the percentage of correctly submitted applications and the percentage of newly applying ADAP clients approved or denied for services within 30 days of ADAP receiving a complete application. Technical assistance visits to enrollment sites provide opportunities for ADAP/HICP case managers and coordinators to gain additional knowledge and clarification of updates on ADAP and HICP policies and procedures. Enrollment sites may also receive annual visits to monitor the efficiency and appropriateness of ADAP and HICP files and charts.

HICP

The monitoring process for the HICP includes internal desk audits of client files whereby applications are checked for completeness and eligibility requirements. HICP has implemented an internal process to review recertification due dates of clients, which provides an improved method of desk monitoring to determine non-compliance and continued eligibility. Additional fields in the HICP CAREWare database enable case managers to monitor premium payment cycles for their HICP clients. Information obtained from CAREWare data is communicated to the case managers and local HICP Coordinators to maximize the effectiveness of the program and discontinue clients who were **30 days** overdue for recertification.

State Program Oversight and Monitoring

The following is a brief description of the positions that have associated program oversight and monitoring duties.

HIV Care Manager: Directs all organizational and operational planning and administration of the Ryan White Part B Program, including: preparation of annual grant applications; federally required monthly, quarterly and annual reports; developing grant budgets based on required input from advisory councils, public hearings, and appropriate DPH staff; supervising program staff and providing monitoring/consultation/technical guidance to directors and staff of 16 health districts and organizations under contract.

Assistant HIV Care Manager: Assists with grant oversight and management; supervises District Liaison Team; responsible for ensuring the development and implementation of appropriate programmatic monitoring policies, tools and activities.

District Liaison: Conducts routine programmatic monitoring of Ryan White service providers to assess the quality and level of services delivered by each funded public health district. Coordinates and conducts client chart reviews in order to assess programmatic contractual compliance including payer of last resort status. Develops follow-up technical assistance/improvement plans as appropriate with individual service providers, as well as procedures for the collection, verification, maintenance and analysis of service and client data. Coordinates, prepares and conducts technical assistance, trainings, and workshops.

QM Team Lead Nurse Consultant: Coordinates Clinical QM Program operations and supervises QM staff members. Ensures the development, implementation, evaluation and revision of the QM plan and work plan. Monitors district QM plans and quarterly reports and provides technical assistance to Part B funded public health districts in the development of local QM plans and nursing/clinical services. Develops and revises HIV-related medical guidelines and other guidelines/polices as indicated. Conducts site visits to review QM plans and activities.

Nurse Consultant: Closely monitors district QM plans and quarterly reports and provides technical assistance to Part B funded public health districts in the development of local QM plans and activities. Coordinates the revisions of nurse protocols, and develops or revises medical guidelines, policies, and/or procedures. Conducts site visits to review QM plans and activities.

Quality Clinical Case Manager: Ensures the development, implementation, and evaluation of statewide Case Management standards and tools. Closely monitors district QM plans and quarterly reports and provides technical assistance to Part B funded health districts in the development of local QM plans and activities. Conducts site visits to review QM plans and activities, and/or to review case management services.

ADAP/HICP Manager: Responsible for managing the daily operation of the ADAP/HICP. Provides technical assistance and recommends policies and procedures for the development and implementation of the ADAP, HICP and other HIV related programs. Monitors ADAP and HICP enrollment agencies for compliance with state and/or federal guidelines through data collection, documentation, and site visits.

ADAP Pharmacy Director: Provides specialized pharmaceutical services related to Georgia's ADAP. Responsibilities include strategic and daily operational planning for ADAP Contract ACP Network, audits of ADAP contracted pharmacies, performance measurement for HIV treatment and adherence, and participation in the Quality Management Program. Provides technical assistance regarding: operations of the management of 340B purchased pharmaceuticals in the areas of drug storage, handling, distribution and documentation as required by law; monitoring drug utilization of ADAP, patient care and pharmacotherapy for HIV clients, and the results of public health initiatives directed at outcomes of therapy and ADAP.

Medical Advisor: Provides medical expertise and technical assistance to the Office of HIV/AIDS, Ryan White Part B/ADAP/HICP program and funded agencies, and others. Responsibilities include participation on the QM Core Team, chairing the HIV Medical Advisory Committee (HIV-MAC), conducting site visits to review clinical performance measures including: management and utilization of antiretroviral therapy; revising and approving the HIV/AIDS-related nurse protocols; providing training to HIV providers and others as indicated; mentoring physicians inexperienced in HIV care; assisting with QM-related reports and assignments; and assisting with development and/or revisions of medical guidelines, polices and/or procedures.

Section 3: Eligibility Policies & Procedures

The following section discusses eligibility policies and procedures for Ryan White Part B, ADAP and HICP services. **For clients who receive only Ryan White Part B services**, meaning they are not enrolled in ADAP or HICP, **sub-recipients are required to keep the same level of documentation in the client file as if the client were on ADAP, unless otherwise noted**.

Eligibility Determination

I. Introduction

In order to enroll into Ryan White Part B services, including ADAP and HICP, individuals must fulfill all eligibility criteria. The client is responsible for providing proof of eligibility for Ryan White Part B/ADAP/HICP to case managers and/or local ADAP/HICP coordinators. All information provided for determining program eligibility will be kept completely confidential. Part B services will not be provided, medications will not be dispensed, and health insurance premiums/ medication co-pays will not be paid until medical, financial, and residency eligibility criteria are confirmed.

Individuals are eligible for Ryan White Part B services if they meet the following criteria:

1. Must have an HIV/AIDS positive medical diagnosis,
2. Must have an income at or below 400% of the Federal Poverty Level (FPL),
3. Must be a Georgia resident, and
4. Must have no other payer source for the services provided

In addition to the criteria listed above, individuals applying for the ADAP or HICP must also meet the following criteria, when applicable:

1. AIDS defining illness, Hepatitis B, HIV nephropathy, HIV related pulmonary hypertension, HIV cardiomyopathy, HIV related encephalopathy, and those who have been on therapy, i.e. HAART experienced

2. Pregnant with no other payer source
3. Have a valid prescription from a Georgia licensed physician
4. Must have recent lab reports no less than six (6) months old; reports must be attached to the application
5. Have cash assets equal to or less than $10,000.00
6. Must be 18 years of age or older (refer to section VI for exceptions)
7. Must not be covered by or eligible for Medicaid or another third-party payer

Please see **Table 2** for a summary table of when eligibility documentation should be collected for each client.

Table 2. Required Documentation Table

	Initial Eligibility Determinations and Once a Year/12-Month Recertification Determination	**Recertification (once every 6 months)**
HIV Status	Documentation required for Initial Eligibility Determination. Documentation is not required for the once a year/12-month period recertification	None
Income	Documentation required	Self-attestation of no change. Documentation required if there are changes *(*NOTE: Clients who have marketplace plans must also report changes in income to the Marketplace)*
Residency	Documentation required	Self-attestation of no change. Documentation required if there are changes
Insurance Status	Documentation required	Self-attestation of no change. Documentation required if there are changes
CD4/Viral Load	Documentation required	Documentation required

II. Medical Eligibility Criteria

In order to be eligible for Ryan White HIV/AIDS Program funded medical care, clients must have a "diagnosis of HIV disease;" however, there are no federal or state legislative requirements for a "confirmed" HIV diagnosis **prior** to linkage. Please refer to **Appendix E** (HIV Testing Algorithm) for the most current testing guidelines.

DHHS guidelines indicate that persons with HIV or AIDS may be offered therapy as soon as they are diagnosed. Completion of the "Clinical Information" section of the Part B/ADAP/HICP

application along with current labs attached (i.e., no older than six [6] months) is required for verification and eligibility.

Acceptable documentation for HIV status shall include, but not be limited to:

- A positive HIV antibody test result (Reactive IA/EIA/ELISA screening test) confirmed by Immunofluorescense Assay (IFA), Nucleic Acid Testing (Aptima), Multispot® HIV-1/HIV-2 Rapid Test by blood or oral fluid.
- A positive HIV direct viral test such as PCR or P24 antigen.
- A detectable HIV viral load (undetectable viral load tests are NOT proof of positive HIV status).
- A viral resistance test result.
- 4th Generation testing.
- A statement or letter signed by a medical professional (acceptable signatories are listed below), on office letterhead indicating that the individual is HIV positive and must accompany a lab test to confirm current HIV status within 60 days. It is the responsibility of the provider to follow up and receive the accompanying lab test from the medical provider's office within the 60-day period. Acceptable signatories include:
    - A licensed physician
    - A licensed physician assistant
    - A licensed nurse practitioner
- Presumptive diagnosis based upon documented lab results, and/or medical therapies prescribed by a previous medical provider.

Medical Exceptions for ADAP enrollment during a Waitlist:

- ADAP enrollment will be approved for pregnant immigrant women during the event of a Waiting List upon the receipt of an eligible ADAP application. The provider must include information in the clinical section regarding the pregnancy. Other pregnant women may access Medicaid.
- Postpartum women (birth within 180 days) needing to continue ARV medication may apply for or resume ADAP services during the event of a Waiting List upon the receipt of an eligible application. The provider must include information in the clinical section.

Adult HIV/AIDS Case Report Form Requirements

The Georgia Adult HIV/AIDS Confidential Case Report Form (**Appendix F**) is required for all **NEW** ADAP and HICP applicants. Failure to attach Case Report Forms to new ADAP and HICP applications will result in an incomplete application. This will ultimately lead to delayed processing and/or denial of enrollment. Adult HIV/AIDS Case Report Forms are not required for persons recertifying for ADAP and HICP services. For ADAP or HICP re-enrollment, a case report may be required if a client's confidential case report cannot be verified from the previous enrollment record.

NOTE: *The SENDSS HIV case report can also be provided as status documentation and is acceptable documentation for the ADAP/HICP applications.*

III. Prescription Eligibility Criteria

Individuals must have valid prescriptions for medications listed on the ADAP formulary (**Appendix G**) from a Georgia licensed physician. If the prescription includes a medication that requires prior approval (e.g., Fuzeon, Selzentry, or those listed under the Hepatitis C Program), the Georgia ADAP Application for Prior Approval Medication form is required (**Appendix H**). A co-receptor tropism assay, trofile test, is required for Selzentry indicating sensitivity (e.g. CCR5 only virus) to the drug. Prescriptions for active and eligible clients may be taken directly to a participating pharmacy in the ACP Network (**Appendix I**).

***NOTE**: Prescriptions for clients who have recently moved to Georgia from physicians licensed in the surrounding states may be filled by a pharmacy in the ACP Network.*

IV. Income Eligibility Criteria

Individuals with household incomes equal to or below 400% of the current Federal Poverty Level (FPL) are eligible for Ryan White Part B, ADAP, and HICP. Clients with incomes that exceed 400% FPL are **not** eligible. Please see **Appendix J** for the most current FPL guidelines.

At the initial enrollment and every subsequent 12-month recertification date, the client must provide documentation of income for all household members. Clients will be able to self-attest during one of their yearly recertification periods **but** must submit all appropriate documentation during their 12-month recertification period (**Appendix K and Appendix L**).

***NOTE**: For eligibility purposes, household is defined as the client, and the client's spouse, dependent children or adult dependents. An adult dependent is a person 18 or older who is counted as part of the household composition and is cared for or supported by the applicant.*

- The "Financial/Income Information Section" of the Part B/ADAP/HICP Application must be completed for new, re-enrollees and for 12-month Recertifications for active ADAP and HICP clients (**see Appendix K**).
- If the client is married, documentation of the spouse's income or verification of no income must be provided.
- If a client is married but separated; documentation of a legal separation must be provided.
- For applicants 18 years and older, only the income and assets of the applicant and the applicant's legal spouse with whom the applicant resides will be considered.
- There may be situations when a client is being supported by his/her parent(s) or living with a friend or with other relatives who are providing food and shelter. Under these circumstances, a client with no dependents, would be counted as a household of one and must complete a notarized Statement of Support Form from the person with whom he/she is living (**Appendix M**).
- If a client states that he/she has income at or below 99% of the FPL (e.g., $1,067.00 or less monthly), a notarized Statement of Support Form must be provided.
- Clients who are self-employed and who do not receive pay checks, may submit a signed notarized statement identifying average monthly wages. The notarized statement will be

accepted by Part B/ADAP/HICP as proof of income along with the most recent or previous year's tax return or tax transcript.

- All sources of income, both taxable and nontaxable, must be considered. Income that must be counted in determining eligibility includes**:**
    - Wages, salaries, tips, etc.
    - Taxable interest
    - Tax exempt interest
    - Ordinary dividends
    - Taxable refunds of state/local income taxes
    - Alimony or other spousal support received
    - Business income/loss
    - Capital gain/loss
    - Other gains/losses
    - IRA distributions – taxable amount
    - Pensions and annuities (veteran and employer-based pensions, retirement and/or disability)
    - Rental real estate, partnerships, S corporations, trusts, etc.
    - Farm income or loss
    - Unemployment income
    - Retirement income from Social Security
    - Disability income from Social Security
    - Other income (jury duty pay, gambling)
- Documentation of income must be included with the Application and subsequent 12-month Recertification Forms. Documentation of income can include the items listed below. A more comprehensive list of income documentation can be found as part of the Modified Adjusted Gross Income (MAGI) Factsheet under **Appendix N**.
    - Previous year's Individual Federal Income Tax Return
    - Previous year's Individual Georgia Income Tax Return
    - Previous year's Federal Tax Transcript
    - Current W-2 (up to 3 months after the most recent year) or current 1099 (accepted up to 3 months after the most recent year)
    - Full or part time employees must provide pay stubs for a full thirty days of consecutive income for pay periods, indicating a year-to-date total, deductions, and the pay period, e.g., weekly, bi-monthly, monthly, etc.
    - Signed employer statements
    - Disability Award Letter indicating the pay period
    - Bank statement, acceptable for Social Security Retirement, VA, SSDI, Pension and/or Annuity
    - Documentation of alimony
    - Signed notarized statement by client identifying average monthly wages
    - Self-employed individuals may also submit a signed notarized statement identifying average monthly wages
    - Form 4797 (sale or exchange of business property)

***NOTE 1**: Total assets cannot exceed $10,000.*

NOTE 2**: If the person providing support to the client refuses to complete the Statement of Support form, the client must make a notation on the form.* ***Only use the updated version of this document. Previous versions will not be accepted with the applications. The Statement of Support cannot be changed or altered after it is signed and notarized.

***NOTE 3:** If a spouse's income is reported as zero, a Statement of Support Form should be submitted with the application as verification.*

***NOTE 4**: Marketplace insured clients receiving premium assistance through HICP may have to submit federal tax filings during recertification. (Please refer to HRSA PCN #14-01; and NASTAD ACA Federal Tax Filing Requirements Health Reform Issue Brief.)*

***NOTE 5**: Employer statements must include employee's dates of employment, title/position, salary, company address and phone number.*

MAGI Requirements

MAGI is the methodology used to determine income, household composition, and family size. It is based on federal tax rules for determining adjusted gross income, with some modifications.
Sub-recipients must utilize the MAGI/FPL Determination Worksheet (**Appendix O**) to determine FPL. The worksheet walks the sub-recipient through income sources and deductions to show the total household income, and corresponding FPL. A copy of the MAGI form must be kept in the client files as part of the documentation for income verification. Forms should be kept for all Ryan White Part B clients, including ADAP and HICP clients. Please see **Appendix J** for the 2021 FPL Guidelines.

NOTE 1**: **Failure to attach income documentation, including the MAGI form described above, to ADAP applications will result in an incomplete application.** MAGI forms must be kept in the client files regardless of whether the client receives ADAP or HICP services or not. MAGI forms must be completed electronically using Excel, saved as a PDF file and updated.* ***Handwritten MAGI forms cannot be calculated properly and will be disallowed.

***NOTE 2:** Calculated income from the MAGI form should match the income documented on the ADAP or HICP application.*

V. Residency Eligibility Criteria

Ryan White Part B/ADAP/HICP applicants must be living in the state of Georgia at the time of application and residency must be documented. Clients will be able to self-attest during one of their yearly recertification periods **but** must submit all appropriate documentation during their 12-month recertification period.

- For ADAP, the "Georgia Residency" section of the application must be completed.
- Documentation of residency must be included in all client charts and must include at least one of the following:

- Copy of lease
- Rent receipt
- Utility bill, home telephone, or cable bill
- Current voter registration card within the last 12 months
- Vehicle registration
- Property tax statement
- Current W-2 (up to 3 months after the most recent year) or current 1099 (accepted up to 3 months after the most recent year)
- SSI, SSDI, TANF, or other assistance award letter issued in their name with local address
- Paycheck stub issued in their name from employer
- Current medical bills or statements within thirty days
- Insurance premium statements

- Persons, living with or supported by family/partner, who do not have the above documentation may prove residency by providing the Statement of Support Form from the family member or friend.
- Persons who are homeless will need a letter on agency letterhead, from their case manager or social service provider, providing the location and dates of residency or the Statement of Support Form completed by the case manager or social service provider. Case managers will have the authority to notarize a statement on behalf of the client, if there is no affiliation with any other agency or shelter.

REMINDER: *If the person providing support to the client refuses to complete the Statement of Support Form, the client must make a notation on the form.* ***Previous versions of this document or handwritten notes will not be accepted with the applications.***

NOTE 1*: A Georgia ID or driver's license, is* ***not*** *adequate proof of residency. One of the approved documents listed above must be submitted for confirmation of residency. A P.O. Box can be used as a mailing address; however, clients must verify address via another means.* ***Documentation with a P.O. Box is not acceptable as proof of residency****.*

NOTE 2*: It is not necessary to be a citizen of the United States or qualified alien to receive Part B/ADAP/HICP services.* ***Applicants do not have to declare or document citizenship or immigration status in order to be eligible for services.***

VI. Age Eligibility Criteria

Applicants should be 18 years of age or older.

NOTE 1*: Children (persons under 18) are generally* ***not*** *eligible for Part B/ADAP/HICP services. Minors must be referred to Medicaid, the Division of Family and Children's Services or other third-party payer for appropriate eligibility determination. If a minor is determined to be ineligible under all these options, and documentation to that effect is provided, exceptions may be considered on a case-by-case basis. In such a case, the local Part B and/or ADAP Coordinator or case*

manager should contact the ADAP/HICP Manager at (404) 463-0416. State ADAP approval must be obtained before any minor may be enrolled in ADAP.

***NOTE 2**: For applicants less than 18 years of age, the income and assets of the applicant and the legal parent or parents with whom the applicant resides will be considered. Income and assets of step-parents and legal guardians shall not be considered.*

VII. Third-Party Payer Coverage

By statute, Ryan White is considered a "payer of last resort," meaning funds may not be used for any item or service for which payment has been made or can reasonably be expected to be made by another payment source. According to HRSA PCN #13-04, recipients and sub-recipients (in this case Georgia and the funded agencies respectively) are required to vigorously pursue enrollment into health care insurance coverage for which their clients may be eligible, including those that are part of the Health Insurance Marketplace.

In order to verify that Ryan White is the "payer of last resort" Ryan White clinics must collect and maintain client documentation regarding client eligibility for other health plans or lack thereof. Documentation needs to include the Other Coverage Screening Form (**Appendix P**), referrals to enrollment assistance, and notes about educational efforts in the client files. Verification that Ryan White is the "payer of last resort" is **mandatory** during both the enrollment and 12-month recertification periods. Copies of informational letters/brochures utilized to educate clients should be kept on record for monitoring purposes.

At the initial enrollment and every subsequent recertification period, **the client must provide proof that they are not covered under another household member's insurance plan**. Clients will be able to self-attest during one of their yearly recertification periods **but** must submit all appropriate documentation during every subsequent recertification period.

***NOTE 1**: For eligibility purposes, household is defined as the client, and the client's spouse, dependent children or adult dependents. For purposes of ADAP enrollment, the Other Coverage Screening Form, or approved equivalent, must be uploaded along with ADAP applications and each subsequent recertification.*

***NOTE 2**: The Other Coverage Screening Form should be updated throughout the year as changes occur. This form must be on file for all clients receiving Part B services and will be reviewed during annual programmatic site visits.*

Medicaid

A client who is receiving Medicaid is **not** eligible for ADAP or HICP services. One exception is if the client receives Medicaid category Qualified Medicare Beneficiary (QMB) assistance ("spend-down"), which requires the client to pay a portion of their medical expenses each month before Medicaid can provide a medical card to meet the remaining expenses. Another exception is Family Planning Medicaid (P4HB), as this category of Medicaid does not provide treatment or services

related to HIV/AIDS. If a client loses Medicaid benefits or is no longer eligible, he/she may qualify for enrollment/re-enrollment in ADAP.

A client who is receiving Medicaid may receive Ryan White Part B medical and/or support services utilizing Part B funds if the services rendered are not covered by the client's Medicaid plan. **Funded agencies are required to be Medicaid certified and must bill for services as appropriate.**

Veteran's Administration (VA) Benefits

Ryan White Program sub-recipients may **not** deny services, including prescription drugs, to a veteran who is otherwise eligible for Ryan White Program services. Sub-recipients may not cite the "payer of last resort" language to force an HIV-infected eligible veteran to obtain services from the VA care system or refuse to provide services. Ryan White Program services to veterans can be refused on the same basis as decisions of refusal for non-veterans. To ensure that veterans have full access to all possible services and to ensure that veterans are obtaining their preferred services, sub-recipients should inform HIV-infected veterans of the benefits, services and physical location of the VA health care system in their area. Sub-recipients may refer eligible veterans to the VA for services when appropriate but may not require that eligible veterans access VA care against their will. ADAP clients who are also eligible for VA Benefits may receive ADAP medications. Please refer to HRSA Policy #16-02 for additional information.

Medicare Part D

Many Medicare beneficiaries with HIV/AIDS qualify for some type of low-income subsidy (LIS). Dual eligible Medicare beneficiaries on Supplemental Security Income (SSI) and currently in a Medicare Savings Program are automatically eligible for full or partial LIS. ADAP Coordinators and other providers of approved enrollment sites should provide assistance with completing applications, providing information, referrals to websites, and plan interpretations to all ADAP clients receiving services in clinics and other agencies.

ADAP clients who are Medicare eligible must apply for a Medicare Part D Plan and maintain current enrollment status throughout the year. Failure to do so will jeopardize Medicare Part D premium costs. Medicare eligible persons without full LIS or "extra help" must also apply for a Medicare Part D plan. Assistance with medication co-payments is available through the ADAP. The Medicare Part D co-pay assistance component of the program will assist individuals with out-of-pocket costs for ADAP approved formulary medications. If ADAP cannot assist with Medicare Part D medication co-payments, assistance is available through the Patient Advocate Foundation (PAF). Persons may apply online at www.copays.org or call 866-512-3861, Option 1. Persons who have been approved for full LIS must be disenrolled from ADAP because of "payer of last resort" guidelines. ADAP clients who are Medicare eligible and remain on the program will be required to recertify every 6 months according to program requirements.

- Full Low-Income Subsidy (LIS) or "extra help"
    - ADAP clients who are eligible for Medicare should enroll in a Medicare Part D plan and **must** complete an application for LIS for submission to Social Security if not already auto enrolled. Clients may apply at a Social Security office or online at www.ssa.gov.

  - The approval or denial letter from Centers for Medicare and Medicaid Services (CMS) must be sent to the state ADAP office by ADAP Coordinators or providers to be placed in the client's file.
  - ADAP clients with income less than 135% FPL, who have enrolled in a Medicare Part D plan and have been "auto" approved for full LIS, will **not** be eligible to continue to receive ADAP services.
- Partial Low-Income Subsidy (LIS) or "extra help"
  - ADAP clients with income between 135% and 150% FPL that are not eligible for full LIS but are eligible for partial LIS or "extra help" will receive assistance from ADAP with co-payments. ADAP will assist with Medicare Part D co-payments through the Pharmacy Benefit Manager (PBM) after the state ADAP office has finalized the process with CMS. The state ADAP office must receive premium and plan information to assist with payments.
  - Documentation confirming that the client is only eligible for partial LIS should be sent to the State ADAP office and filed in the client's chart upon receipt.

***NOTE 1**: The ADAP will consider exceptions on a case-by-case basis for clients who apply for LIS and are denied. For example, these clients may have assets beyond the federal limits to qualify for the federal subsidy.*

***NOTE 2**: Persons who cannot access their regimen through their Medicare Part D plan must submit the proof that the medications are not available in order to remain on the program.*

- ADAP clients with income over 150% FPL but not exceeding 400% FPL who are eligible for Medicare and not eligible for additional assistance from Social Security must apply for a Medicare Part D plan. ADAP will assist with Medicare Part D medication co-payments on the MCARE medication copay assistance program through the PBM.

- ADAP Coordinators, Case Managers, or Providers' Responsibilities:
  - Assist ADAP enrollees/clients who are eligible for Medicare with enrollment into a Medicare Part D plan and application for LIS.
  - Submit documentation confirming Medicare Part D plans and LIS to the state ADAP office immediately upon receipt. If client is not eligible for Full LIS, the ADAP office must receive premium and plan information to assist with payments.
  - Notify the state ADAP office to discontinue ADAP services in order to comply with the "payer of last resort" requirement, when the Medicare Part D plan and HIV medication coverage are confirmed. Information regarding the client's ADAP status will be indicated by the *end date* in the PBM network.
  - Inform clients of this entire process to alleviate anxiety.

***NOTE**: If additional assistance is needed, ADAP Coordinators may contact the State Health Insurance Assistance Program, GeorgiaCares, at 866-552-4464. Trained counselors are available to provide free, unbiased information in relation to the Medicare Prescription Drug Program and can assist clients in the enrollment process.*

It is the responsibility of the Medicare eligible ADAP client to adhere to the following:

- Bring all documentation received from Social Security and Medicare Part D plans to ADAP Coordinators or providers for assistance and clarification.
- If the annual income is below 150% of FPL, apply for LIS if not already auto enrolled. Individuals with incomes between 135% and 150% FPL may also be eligible for partial LIS. Apply at any Social Security office or online at www.ssa.gov.
- Review the list of Georgia plans and enroll online at www.medicare.gov. Pay special attention to plan costs, pharmacies, and drugs covered by each plan, including:
    - The monthly premium amounts
    - Annual deductible, if any
    - Plans' co-payments and co-insurance amounts to obtain covered medications
    - Coordinating pharmacies
    - All antiretroviral medications must be covered, but other needed medications may not be on plan formularies
    - Provide the ADAP state office proof of enrollment in a Medicare Part D plan upon receipt of information about the plan or during the next recertification appointment
    - Submit premium and plan information in order for DPH to assist with premium payments if requesting assistance with premiums
    - Contact his/her ADAP provider or case manager to schedule an appointment, if he/she needs individual counseling about Medicare Part D
    - Ensure monthly Medicare Part D premiums are paid
    - If not eligible for LIS, submit documentation to confirm the denial
    - ADAP clients who are Medicare eligible and remain on the program, must recertify every 6 months according to program requirements
    - Comply with all ADAP rules and regulations

***NOTE**: The State ADAP office may assist with premium payments. In cases where the ADAP cannot assist with premium payments, clients will need to pay premiums out-of-pocket if they do not qualify for full LIS. In these cases, individuals should carefully consider plans with low premiums. Failure to pay premiums will jeopardize eligibility for ADAP and can make Medicare Part D costlier in the future. ADAP will require proof of enrollment as part of its recertification process. A 1% increase in premiums will be added for each month a beneficiary was not enrolled in Medicare Part D. Exceptions exist for retirees with healthcare benefits of equal or greater value.*

For a list of Georgia's ADAP and Medicare Part D FAQs, please see **Appendix Q**.

Private Health Insurance

Sub-recipients are required to make every effort to enroll Ryan White Part B/ADAP eligible individuals into insurance coverage options for which they qualify, including private coverage options through the Health Insurance Marketplace. Clients must be informed that the Georgia Ryan White Part B/ADAP will provide health insurance assistance through the HICP for clients enrolled in insurance plans available in their area, based on the guidance provided in HRSA Policy #13-05. In addition, clients must know that in order to receive health insurance premium assistance they are required to apply for premium tax credits and cost sharing subsidies, if applicable. **If clients qualify**

for premium tax credits and subsidies, *100% of those credits* must be applied toward the insurance plan premiums before the client seeks support from the Ryan White Program.

As clients enroll or re-enroll in insurance plans, they may be responsible for a portion of their monthly insurance premium or other out-of-pocket costs such as co-payments and deductibles. Some clients may require assistance with these out-of-pocket costs. Ryan White funds may be used for premiums and medication co-pay assistance.

In order to verify that Ryan White is the "payer of last resort" Ryan White clinics must collect and maintain client documentation regarding client eligibility for other health plans or lack thereof. Documentation must include the Other Coverage Screening Form (**Appendix P**), referrals to enrollment assistance, and notes about educational efforts in the client files. Educational efforts include educating clients about other coverage options which may available to them, providing them with information as to where they can get assistance with enrollment (e.g., contact information for Navigators), and informing clients about any consequences for not enrolling in a plan if they are eligible. Copies of informational letters/brochures utilized to educate clients should be kept on record for monitoring purposes. Verification that Ryan White is the "payer of last resort" is mandatory during both the enrollment and every subsequent recertification period.

If a client misses the enrollment period, Ryan White Part B/ADAP can continue to pay for services, but enrollment sites must make every attempt to have the client enroll during the next open enrollment period. Ryan White Part B/ADAP can continue to pay for items or services for a client up to the start date of coverage if they are not covered by another funding source.

A client with health insurance that covers ADAP formulary medications prescribed to him/her is **not** eligible to receive those medications from ADAP. If a client provides documentation that his/her health insurance has no prescription benefits he/she may be enrolled in HICP medication-only assistance. If a health insurance plan does not cover the full brand regime as prescribed by a provider and no other generic medications can be considered, a client may remain on the HICP and apply for medication-only assistance providing documentation/ justification from the physician. In addition, a client who has a financial cap on pharmaceutical benefits may also be enrolled. Any available benefit must be exhausted in order for a client to be eligible for HICP medication-only assistance. When clients have exhausted their private insurance prescription benefit, they are eligible for HICP medication-only assistance if they continue to meet all HICP eligibility requirements and are actively enrolled. If a client has a limited annual prescription benefit (e.g., $1,000 cap) this benefit cannot be reserved for non-ADAP covered drugs. The client would be eligible for HICP medication-only assistance until their private insurance prescription benefit is renewed (i.e., for a monthly cap, when a new month begins, or for an annual cap, when a new calendar year begins). Clients must utilize prescription benefits if available. **Clients who voluntarily drop active health insurance coverage with prescription benefits will be required to submit a justification before an ADAP application is reviewed and considered approved based on eligibility.** Clients should be notified that if there are future ADAP funding constraints, they may not be able to stay on full-pay ADAP if they are eligible for public or private insurance.

The ADAP/HICP and Part B sub-recipients must vigorously pursue and recoup all cost-sharing premium and tax credit refunds issued to a client, but due to the program. During the application process, the client must sign the Notification of Client Responsibility for Participation Form (**Appendix R**) for participation in the HICP. The client certifies receipt of participation responsibility, which includes the acknowledgement that he/she may be responsible for the first month's payment, and responsibility to return refunds received from the insurer back to the ADAP/HICP program. Upon approval, HICP participants will receive notification of eligibility and the conditions of program participation. In the approval letter, participants are reminded to submit refunded premiums to the Georgia DPH ADAP/HICP program.

Participants who receive a premium overpayment refund from the insurer, must forward all funds to the Georgia ADAP/HICP program within 30 days of receipt. Refund checks should be endorsed and made payable to the Georgia Department of Public Health. Failure to remit payment to the Georgia ADAP/HICP program may affect current or future ADAP/HICP eligibility. If a client receives a refund from the health plan issuer, ADAP/HICP case managers should electronically document when the participant received the refund, amount of the refund, and document when the endorsed refund check issued by the insurer was returned to DPH.

If a participant receives a refund for premium payments paid for by DPH after ADAP/HICP disenrollment, the participant must forward all funds to the Georgia ADAP/HICP program within 30 days of receipt. If the client receives a tax credit refund due to premium overpayment, the participant must forward the tax credit refund to the Georgia ADAP/HICP program within 30 days of receipt. The client is responsible for setting up a payment agreement with DPH before becoming eligible for re-application to the ADAP/HICP program if the payment is not received within the allotted 30 days. The ADAP/HICP program will accept a repayment agreement. The client must submit the Repayment Agreement Form (**Appendix S**) through the case manager at the ADAP/HICP enrollment site. The Repayment Agreement will be approved or denied by the Georgia ADAP/HICP program administrators. If the repayment agreement is approved, the first payment should be mailed to Georgia DPH-ADAP/HICP in the form of a money order each month. Failure to remit payment to the Georgia ADAP/HICP program as agreed for 60 consecutive days will affect current or future ADAP/HICP eligibility.

VIII. Nursing Homes/Inpatient Care

A client who is in a nursing home/hospital or hospice is **ineligible** for Ryan White Part B/ADAP services. **ADAP covers only outpatient prescriptions.** Ryan White Part B/ADAP cannot pay for services that would otherwise be paid from another source. If the client is in a nursing home/hospital/hospice and has no source of payment he/she is most likely eligible for Medicaid. Medicaid should pay for the cost of all care including medications. Once discharged, the client may apply/reapply for Ryan White Part B/ADAP.

IX. Federal/State Prisons, Jails and Correctional Facilities

Ryan White Part B funded agencies cannot use grant funds to pay for core medical and support services provided to PLWH in Federal or State prison systems, because such services are generally provided by these systems.

Funded agencies cannot use grant funds to pay for core medical and support services provided to PLWH in other correctional systems or subject to community supervision programs, if these services are provided by those systems/programs. Funds cannot pay for services for incarcerated persons who retain private, state or federal health benefits during the period of their incarceration.

In cases where a local correctional system, such as a county jail, cannot provide care because there is no funding available, assistance may be provided on a case by case basis with prior approval from the state office. Documentation, such as a signed letter from the sheriff's department, must be submitted stating that the correctional facility does not have funding to provide care, and to show that the program is meeting payer of last resort regulations.

The funded agency will need to coordinate with the correctional facility and inform the state how it plans to do so. The agency will need to complete general intake for the client and determine eligibility prior to rendering any services. Medication assistance will need to be provided through the Stop Gap Medication process. **If approved, assistance can be provided for a maximum of 90 days**, at which point the case will need to be revisited.

Please refer to HRSA PCN #18-02.

X. Emergency Response and the ADAP Emergency Program

The response to any emergency or disaster must be a coordinated community effort. The Georgia Ryan White Part B/ADAP/HICP program and its partner agencies must be in continuous collaboration in order to prepare for, implement, and continually update dynamic plans that minimize the effect on the care provided to clients in the event of a disaster. Plans should include the primary points of contact with their current contact information and an inventory of resources that will be available at the local level.

In the event of a Ryan White clinic closure or change of operating hours, the clinic will need to notify the Office of HIV/AIDS and clients at least 48 hours in advance of such changes taking effect. Office of HIV/AIDS staff will call each funded agency impacted, inclusive of GA health districts and community business organizations, to ascertain the status of closings and re-openings. In the event that a Ryan White clinic will be closed for a significant amount of time, it is expected that clients should be contacted with a status update to when the clinic will re-open and pertinent information should be shared with the client. This includes address and phone number of the nearest operating Ryan White Clinic, or name of temporary medical or support services provider to contact in order to schedule an appointment. If transportation can be arranged for a Ryan White client to see a temporary provider at the new location that would be optimal.

Ryan White clinics are encouraged to coordinate response and preparedness efforts across boundary lines when responding to a local incident/emergency. Clinics can coordinate cross-regional/district requests for assistance without needing state support to respond to a local incident/emergency.

Please note that in the event of a disaster the most critical area of the Ryan White Part B program and its components is the AIDS Drug Assistance Program. This program must be continued in the event of an emergency.

The Georgia Ryan White Part B/ADAP/HICP program understands that due to some natural disasters, other states may be affected and PLWHA may seek assistance in Georgia. To address this, **the program created the ADAP Emergency Program (AEP), intended to assist victims of a Natural Disaster coming into Georgia from an affected neighboring state.** An eligibility assessment should be conducted at a local Ryan White Part B ADAP enrollment site. Approved applications will give participants access to HIV medications for a **maximum of 90 days**. All applicants must provide the following documentation:

- State ID or Driver's License
- AEP Statement of Support Form **(Appendix T)**
- AEP Self-Attestation Form **(Appendix U)**

The AEP Statement of Support Form must be notarized. Please note that some coordination of information from the applicant's previous state will be required. When ready to submit a complete AEP application, please upload all documents by scanning them into CAREWare under the "Application Tab", in the "ADAP Emergency Program (AEP) Application" link. Please remember to check the "AEP Ready for Review" box. Approved AEP applicants must access their medications through the ADAP Contract Pharmacy (ACP) Network. All medications must be on the approved Georgia ADAP formulary.

Part B/ADAP/HICP Application

A client must apply to receive Ryan White Part B/ADAP/HICP services in person at a local Part B primary care clinic or ADAP/HICP enrollment site (e.g., designated Public Health Departments or other approved agencies). The client, local Part B and/or ADAP/HICP coordinator, case manager, and the physician must sign the initial application and 12-month comprehensive recertification application. The Self Attestation Recertification Form only requires signatures of the client and case manager. Proof of program eligibility is required as described in this document.

I. Paperless Electronic Eligibility and Enrollment Process

Effective September 2013, a Paperless Electronic Eligibility and Enrollment Process for Ryan White Part B/ADAP/HICP was implemented to provide a more efficient enrollment and recertification process. Electronic enrollment allows Case Managers and ADAP Coordinators to electronically enroll and review the eligibility of clients during the interview process utilizing an enhanced application created in CAREWare. The utilization of CAREWare for enrollment allows staff to review and approve applicants and send Approval Packets electronically.

A Georgia Ryan White Part B/ADAP/HICP application must be completed during a face-to-face interview with the applicant at a designated site. Applications must not be processed via telephone. The Ryan White Part B/ADAP/HICP application must be completed per instructions for consideration of enrollment into the program. All applications must include the required eligibility documentation as outlined in this document. **ADAP coordinators or case managers must ensure**

that all parts of the application are complete prior to submission, that all documentation is uploaded, and that the "Ready for Review" box is checked and "Ready for Review" date is entered when submitting an application. The local ADAP/HICP Coordinator or case manager must review the application to ensure that it is complete and contains all supporting documentation (see checklist on the application).

If a client is applying for the HICP, the corresponding section of the application must be completed (**Section VII of the application**). The HICP is available only for residents of Georgia who are enrolled through District Ryan White Part B/ADAP/HICP approved enrollment sites. In addition, HICP applications **must** include the Notification of Client Responsibility for Participation Form (**Appendix R**), summary of benefits, premium statement, insurance card, authorization to release information, and the Adult HIV/AIDS Case Report (**Appendix F**). Upon receipt of an HICP application, ADAP/HICP staff verifies the amount of the premium, the type of coverage along with extent of medication coverage available under the plan. Plans without comprehensive coverage will not be covered and the persons applying are therefore ineligible. The HICP will pay COBRA or individual policy premiums. Health insurance premiums will not be paid until medical, financial, residency and active insurance coverage are confirmed, and no other payers are identified. The HICP also covers medication co-pays and deductibles, in addition to premiums, for eligible individuals.

***NOTE 1**: **Failure to submit the Notification of Client Responsibility for Participation Form and any of the other above referenced documents will result in an incomplete HICP application status and a delay in payment processing.** These documents are required for all new applications and recertifications.*

***NOTE 2**: A case manager, nurse, physician, department staff, or other unrelated person is **never** permitted to sign a client's name, or to sign in the place of the client for any reason. A caretaker or spouse may not be allowed to sign, unless the client is completely physically incapacitated and cannot sign his/her name. There must be written justification for caretaker or spouse signatures with the completed application packet.*

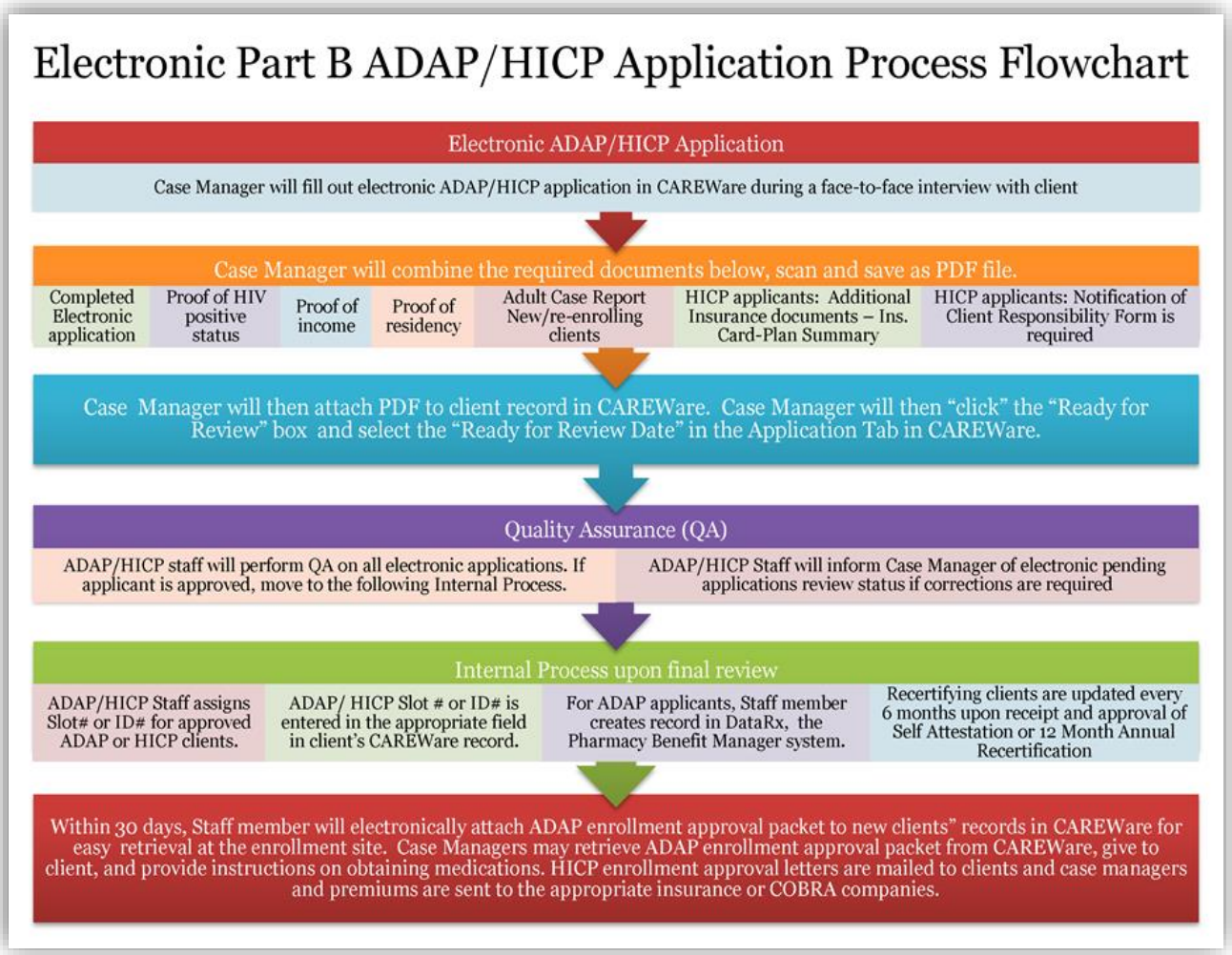
II. Incomplete Applications

Incomplete Applications **cannot** be processed.

***NOTE 1:** The Georgia State ADAP Office does not permit listing "Signature on file," or "Client unable to sign." Only a legal guardian may sign for a client who has been adjudicated incompetent by the court. A copy of the court order for an incompetent person, or the custody order must accompany the completed application.*

***NOTE 2**: It is the responsibility of the local ADAP Coordinator or case manager to ensure applications are complete prior to submission. An incomplete application or recertification extends and delays the time for approval and jeopardizes access to medications or payments for health insurance premiums under the HICP.*

Figure 2. Application Process



Eligibility Recertification

All Ryan White Part B and ADAP clients are required to recertify **every six months**. Clients will be able to self-attest during one of their six-month recertification periods but must submit all appropriate documentation during their 12-month recertification. The local ADAP Coordinator or case manager should initiate the recertification process during a face-to-face interview. Please see **Table 2 (page 17)** for a summary table of when eligibility documentation should be collected for each client. Refer to **Appendix L** for a copy of the Self-Attestation Form.

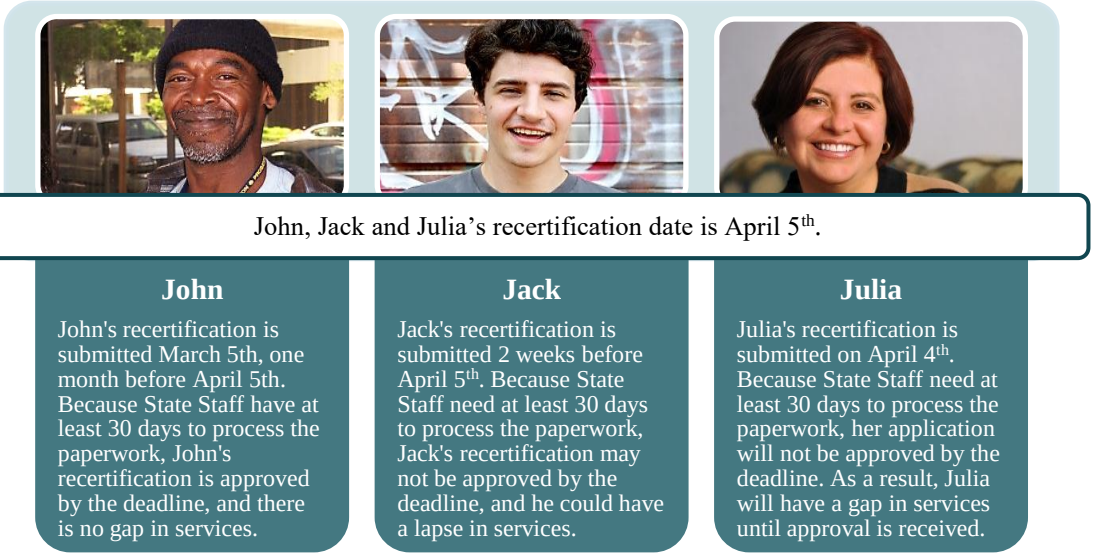
I. Recertification

- Local ADAP Coordinators and/or case managers must establish a procedure to track client recertification dates at the local level.
- ***The 12 Month Annual Comprehensive Recertification or Self-Attestation Form must be completed and submitted*** **to the Office of HIV/AIDS** ***on or before the last day of the fifth month*** **after the initial enrollment or last recertification.** For example, if a client was

enrolled on January 15th, the Self-Attestation recertification must be complete and submitted to the ADAP office by June 30th. **It is advisable to request that clients recertify early and not wait until the month that the recertification should be completed. See Figure 3 for example scenarios**.

- Eligibility for the Ryan White Part B/ADAP must be reviewed and verified to ensure that the Program remains the "payer of last resort." During recertification, the local ADAP Coordinator or case manager must verify if there were any changes in income, insurance, pregnancy, or residential status. If there are changes, the corresponding documentation must be attached to the 12-month Annual Comprehensive Recertification or Self-Attestation Form.
- The local ADAP Coordinator or case manager must review the Recertification Form to ensure that it is complete before submitting to the State ADAP office. Incomplete Recertification Forms **cannot** be processed and **will not** be approved until all supporting documentation is submitted.

Figure 3. Recertification Scenarios



II. Failure to Recertify

- Failure to complete and submit the 12-month Annual Comprehensive Recertification or Self-Attestation Form and supporting documents **by the due date** will result in the client's inability to pick up medications and/or discontinuation from the program. The "End Date" in the PBM system indicates the last day that a client may pick up medications.
- Clients may apply for **re-enrollment** (if there is not a waiting list) at a later date if they are able to supply appropriate documentation.
- If there is a waiting list, re-enrolling clients will be prioritized along with new clients according to the established criteria.

ADAP Medications/ADAP Contract Pharmacy (ACP) Network

The main objective of the ACP Network is to provide comprehensive and convenient pharmacy services while maintaining cost savings to the Georgia AIDS Drug Assistance Program (ADAP). The mechanism

used for providing ADAP medications to eligible clients entails contracting with multiple retail pharmacies to access professional, timely, and confidential "point of sale" pharmacy services processed through a PBM. The PBM and pharmacies operate in accordance with section 340B of the Public Health Service Act.

The ACP Network is a closed pharmacy network for ADAP uninsured clients. It establishes a statewide point of service pharmacy network, that partners with the ADAP program to ensure formulary adherence, pays only for prescriptions obtained by an eligible ADAP client, provides medication counseling and monitors compliance and adherence in coordination with the contracted PBM, medical providers and ADAP case managers. The ACP Network allows eligible ADAP clients to utilize any participating ACP of their choice for ADAP prescription services.

For HICP insured clients there is an open pharmacy network provided by the PBM. Participating ACP Network pharmacies are included in this network along with the entire statewide PBM retail pharmacy network. HICP clients also reserve the right to utilize the participating pharmacy of their choice for prescription services.

I. ADAP Formulary

The Georgia ADAP formulary (**Appendix G**) includes all required core classes of Food and Drug Administration (FDA) approved antiretroviral agents and a limited number of drugs to treat/prevent opportunistic infections. Drugs are added to the formulary based on the recommendations of the HIV Medical Advisory Committee and the delegated HIV and ADAP pharmacy staff. Eligible clients can access all formulary medications; however, some drugs require prior approval.

II. Prior Approval Medications

Some medications on the ADAP formulary require prior approval. In addition to the other documentation required, the Georgia ADAP Application for Prior Approval Medications (**Appendix H**) must be completed and submitted to the State ADAP Office along with all required supporting documentation. The HIV Medical Advisor or designee will review all prior approval applications for approval or denial. If an application is denied, the Medical Advisor will contact the prescribing provider to discuss or request additional information. All clients have the right to appeal a denial decision (see Fair Hearings and Grievance Policy).

Table 2. Prior Approval Medications

GEORGIA ADAP PRIOR APPROVAL MEDICATIONS		
BRAND NAME	GENERIC NAME	COMMENT
Fuzeon	*Enfuviritide*	*Prior Approval required on all new prescriptions for FUZEON (enfuvirtide). Fuzeon in combination with other antiretroviral agents is indicated for the treatment of HIV-1 infection in treatment-experienced patients with evidence of HIV-1 replication despite ongoing antiretroviral therapy.*
Selzentry	*Maraviroc*	*Trofile® test is required indicating sensitivity, i.e. CCR5 only virus identified, to the drug. The test will be the responsibility of the ADAP*

GEORGIA ADAP PRIOR APPROVAL MEDICATIONS		
BRAND NAME	GENERIC NAME	COMMENT
		enrollment site until the Office of HIV/AIDS Part B Program identifies a formal viable method to fund the test.
Harvoni	*Ledipasvir/Sofosbuvir*	*Prior approval required on all initial fills for Hepatitis C Medication program.*
Sovaldi	*Sofosbuvir*	*Prior approval required on all initial fills for Hepatitis C Medication program.*
Zepatier	*Elbasvir/Grazoprevir*	*Prior approval required on all initial fills for Hepatitis C Medication program.*
Epclusa	*Velpatasvir-Sofosbuvir*	*Prior approval required on all initial fills for Hepatitis C Medication program.*
Mavyret	*Glecaprevir-Pibrentasvir*	*Prior approval required on all initial fills for Hepatitis C Medication program.*
	Ribavirin	*Prior approval required on all initial fills for Hepatitis C Medication program.*

NOTE: Georgia Hepatitis C medications are currently not available as the program is currently on hold due to funding constraints.

III. Hepatitis C Program

NOTE: Georgia Hepatitis C services are currently on hold due to funding constraints.

- The Georgia ADAP Application for Prior Approval Medications **(Appendix H)** must be completed by the case manager and the PA, RN or Prescribing Physician for Hepatitis C Program medications.
- The Application for Prior Approval Medications, with the supporting documentation (CD4/Viral Load/Hepatitis B/Hepatitis C labs, MELD, FIB, etc.), must be faxed to DPH for review.
- The application must be reviewed for completeness by DPH staff and approved/denied by the DPH Medical Advisor.
- Electronic notification (an approval or denial letter) with detailed recommendations, will be faxed to the case manager and prescribing physician.
- With receipt of the approval letter, the case manager, client, or prescribing physician will contact the ADAP Contract Pharmacy to fill the prescription. The pharmacy will receive an initial rejection. The Medication Override Request Form **(Appendix V)** should be completed and submitted to DPH for processing.
- Upon completion of the Override Form, the program will review the form, complete the override process and forward the PA# to the pharmacy to fill.

IV. Medication Changes

- Prescriptions for medication changes may be written, called in, faxed or e-scribed to a participating pharmacy in the ACP Network.
- Medication changes occurring at the time of recertification do not eliminate the requirement for six-month recertification.

V. Medication Counseling and Pick-up

- All participating pharmacies in the ACP Network offer pharmacist to patient medication counseling and allow the client an opportunity to ask questions and review information.
- All clients must pick-up their medications in person or receive medications delivered to the client, client's caregiver, or designated agent's home address from an ACP Network participating pharmacy. Delivery is prohibited to enrollment sites, clinics, doctor's offices, etc.
- For more information please see the current Department of Health and Human Services (DHHS) HIV-related Guidelines, available online at http://www.aidsinfo.nih.gov/guidelines.

VI. Medication Prior Approval Request for Travel

- The Medication Override Request Form (**Appendix V**) must be submitted to the ADAP/HICP Office, along with supporting documentation for review.
- The request form must be submitted 30 days prior to the participant's travel date, and the request must not exceed a 60-day supply. **Allow up to 10 business days for approval.**
- The request for travel must meet the following eligibility criteria before consideration and approval:
    - Current ADAP/HICP program participation
    - 90 consecutive days of medication utilization
    - Complete Medication Override Request Form
    - Supporting Documentation (i.e. Travel itinerary; documenting the client's first and last name, date of departure and date of return.)

VII. Lost/Stolen Medication

- The Medication Override Request Form (**Appendix V**) must be submitted to the ADAP/HICP Office, along with supporting documentation for review.
- The Ryan White Part B ADAP/HICP program monitors utilization and limits ADAP/HICP formulary medications to a 30-day supply per client.
- Requests for replacement of lost or stolen HIV or Hepatitis C medication are subject to review by the ADAP/HICP program to ensure that the program remains the "payer of last resort." All other medication assistance programs must be explored before a request is submitted.
- The local ADAP/HICP case manager must facilitate the request and ensure that all required documents are complete for review. **Allow up to 5 business days for approval.**
- Replacement medication requests are **limited to one approval per year, and** must meet the following eligibility criteria before consideration and approval:
    - Current ADAP/HICP program participation
    - 90 consecutive days of medication utilization
    - Complete Medication Override Request Form
    - Supporting Documentation (i.e. Case report for stolen vehicle, burglary, fire or theft.)

ADAP Waiting List

The ADAP is sometimes unable to meet the demand for new enrollments due to insufficient funding. Should ADAP experience the inability to serve all eligible applicants, the Ryan White Part B ADAP/HICP Program will implement a waiting list. During the implementation of a waiting list, the state office will provide

letters which can be forwarded to Pharmaceutical Patient Assistance Programs (PAPs) to ensure that applicants have access to medications.

Discontinuation of Services

ADAP Coordinators or case managers must inform the state Ryan White Part B ADAP/HICP Program when a patient discontinues or terminates ADAP or HICP services. The ADAP/HICP Discontinuation Form (**Appendix X**) must be completed and sent to the state.

I. Reasons for Discontinuation

Discontinuation or termination of services from **ADAP** may occur for several reasons including, but not limited to:

- The client has been determined eligible for Medicaid benefits
- The client has obtained or currently has private insurance, or other third-party payer benefits, with prescription drug coverage for HIV medications
- The client's household income rises to more than 400% of the current FPL
- The client has been approved for LIS benefits under Medicare Part D
- The client moves out of Georgia, or cannot be located
- The client does not reside in the state of Georgia
- The client fails to pick up medications, for more than 60 days, and is refusing to adhere to the medication regimen despite counseling, support or other assistance offered
- The client fails to recertify
- It is discovered that the client failed to report substantial income, or insurance benefits that made him/her ineligible at the time of application, or subsequent to application
- The client fails to provide necessary proof of eligibility
- The client is placed in an institution such as a nursing home, hospital, hospice, state or federal prison, or jail for more than 30 days
- The client has died

NOTE: *If the ADAP office has not received a Recertification Form within 30 days of the expiration of the due date and has not received any notification from the case manager or ADAP coordinator, the state office ADAP staff will notify the case manager or ADAP Coordinator that the client will be automatically moved to inactive status and discontinued from the program.* ***Clients may later apply for re-enrollment*** *(if there is not a waiting list) if they are able to supply appropriate documentation.*

Discontinuation or termination of services from **HICP** may occur for several reasons including, but not limited to:

- Failure to recertify
- Termination of COBRA coverage
- Moved or relocated
- Income exceeds eligibility requirements
- Employed with affordable coverage
- Client has received a refund of insurance premiums paid by DPH and has not returned the refund to the state office

- Another payer is identified
- The client fails to provide necessary proof of eligibility
- Incarcerated for more than 30 days
- Admitted to hospice
- The client has died

II. Failure to Pick Up Medications and Discontinuation

- If a client fails to show at all for 60 or more days to pick up their medications, he/she must be discontinued from ADAP.
- The case manager or ADAP Coordinator should make a minimum of two attempts to contact the client after he/she fails to pick-up their medications after the first month. Communication with the client and/or attempts to contact the client must be documented in the client's record.

***NOTE**: This does not necessarily preclude later re-enrollment into the Program. An ADAP Application must be submitted for re-enrollment (**Appendix K**).*

III. Procedures for Discontinuation

Enrollment sites are instructed to do the following:

1) Complete the ADAP/HICP Discontinuation Form in CAREWare (**Appendix W**).
2) Document the reason for disenrollment on the form**,** noting that the client was notified of the action or that attempts were made to notify the client of the action.
3) Document the date of discontinuation.
4) Upload the discontinuation form in CAREWare and mark it "Ready for D/C."

Security and Confidentiality

Ryan White Part B funded agencies, local ADAP/HICP enrollment sites and the ADAP/HICP State Office must take the following steps to ensure all clients' security and confidentiality.

- All personnel must ensure that client charts are secure, and that client confidentiality is maintained.
- All personnel must sign confidentiality agreements and agreements must be kept on file.
- All sites must ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA).
- Client charts must be kept in a locked area when not in use.
- If information is maintained in an electronic format, computers must be password protected and secure while in use (e.g., placed with screen out of view, always attended, and turned off when unattended).
- Access to areas containing client charts, computers, and medications must be restricted to authorized personnel only or clients/visitors with escorts.

Fair Hearings and Grievance Policy

All Ryan White Part B, ADAP and HICP applicants have a right to make a grievance (complaint) and request a fair hearing if they feel they have been erroneously denied assistance due to medical reasons or criteria, or the State ADAP/HICP office has delayed the processing of an application. In addition, local Ryan White clinics and ADAP/HICP enrollment sites must have local grievance policies and processes in place.

I. Fair Hearing Regarding Application or Recertification Process

- Requests for Fair Hearings regarding the Application or Recertification process must be made in writing and submitted within 10 business days of the denial or discontinuation of services.
- The request must include the following:
  - A written request for a Fair Hearing stating the reason the applicant feels that he/she should have been approved for the program.
  - A copy of the original application.
  - Any documentation that supports the applicant's position.
  - A copy of the denial letter from the Office of HIV/AIDS.
- Please submit requests to:
  - Local District or Approved Agency HIV Coordinator or Manager, **and**
  - State ADAP/HICP Manager
    Georgia Department of Public Health
    Office of HIV/AIDS
    2 Peachtree Street NW
    12th Floor
    Atlanta, GA 30303-3186
- The State ADAP/HICP Manager will respond to the client's request within 10 business days.
- If the client does not agree with the answer, the client may request a face-to-face meeting with the local ADAP Coordinator or case manager, the State ADAP/HICP Manager, and a representative of the client's choice.
- The State ADAP/HICP Manager will issue a written decision within 10 business days.
- If the client does not agree with the decision, he/she may appeal to the HIV Care Manager or Office of HIV/AIDS Director in writing.

II. Fair Hearing Regarding Medical Eligibility

- Requests for Fair Hearings regarding denials due to medical criteria must be made in writing and submitted within 10 days of the denial or discontinuation of services.
- The request must include the following:
  - A written request for a Fair Hearing stating the reason the applicant feels that he/she should have been approved for the program.
  - A copy of the original application.
  - Any documentation that the applicant has to support their position.
  - A copy of the denial letter from the Office of HIV/AIDS.
- Please submit requests to:
  - Local District or Approved Agency HIV Coordinator or Manager, **and**
  - State ADAP/HICP Manager
    Georgia Department of Public Health
    Office of HIV/AIDS
    2 Peachtree Street NW
    12th Floor
    Atlanta, GA 30303-3186
- The State ADAP/HICP Manager will respond to the client's request within 10 business days.

- If the client does not agree with the answer, the client may request an appeal to the HIV Medical Advisory Committee.
- The Chairman of the HIV Medical Advisory Committee will consult the Medical Advisory Committee and respond in writing to the client within 10 business days.

III. Grievance Policy

- All sites must have a documented grievance policy and process.
- The Grievance Policy must be displayed in a highly visible area and convenient to clients.
- Clients must be made aware of their Rights and Responsibilities including the grievance process.
- Local grievance policies must contain language that provides the client with contact information at the state office should the client feel their grievance was not addressed at the local level.
    - **State Contact:**
      HIV Care Manager
      Georgia Department of Public Health
      Office of HIV/AIDS
      2 Peachtree Street NW
      12th Floor
      Atlanta, GA 30303-3186

References

- Georgia Department of Public Health, Office of Nursing, Guidelines for Public Health APRN Prescriptive Authority
- Georgia Department of Public Health, Office of Nursing, Nurse Protocols for Registered Professional Nurses in Public Health
- Georgia Ryan White Program Part B Quality Management Plan April 2021 - March 2022
- HRSA Clinical Care Guidelines and Resources
- HRSA/HAB Performance Measures: Performance Measure Portfolio
- HRSA/HAB Policy Notices and Program Letters
- HRSA Ryan White Part B Manual, (Last Revised 2015)
- HRSA ADAP Manual, (Last Revised 2016)
- HRSA Ryan White Part B National Monitoring Standards:
    - Universal
    - Program
    - Fiscal
- Ryan White HIV/AIDS Program Legislation
- National HIV/AIDS Strategy (NHAS)

APPENDICES

Appendix A: Part B Primary Care Clinics

District 1-1 (Rome)
Northwest GA Specialty Care Clinic
16 East 12th Street, Suite 202
Rome, GA 30161

Janet Eberhart 706-295-6701
Mon, Wed-Thurs 8:00 am - 5:00 pm
Tuesday 8:00 am - 6:00 pm
Friday 8:00 am - 2:00 pm

Satellite Clinic
Catoosa County Health Department
145 Catoosa Circle
Ringgold, GA 30736

Janet Eberhart 706-295-6701
2nd Thursday 8:00 am - 2:00 pm

Counties include: Bartow, Catoosa, Chattooga, Dade, Floyd, Gordon, Haralson, Paulding, Polk, and Walker

District 1-2 (Dalton)
The Living Bridge Center
1200 West Waugh Street, Suite A
Dalton, GA 30720

Jeff Vollman 706-281-2360
Monday - Thursday 7:30 am - 5:30 pm

Satellite Clinic
Cherokee Co. – Canton Health Department
130 Riverstone Terrace, Suite 102
Canton, GA 30114

Ellie Purdy 470-863-5700
Monday - Thursday 7:30 am - 5:30 pm

Satellite Clinic
Fannin County Health Department
95 Ouida Street
Blue Ridge, GA 30513

706-281-2360
Once a month, call for schedule
9:00 am - 4:00 pm

Counties include: Cherokee, Fannin, Gilmer, Murray, Pickens, and Whitfield

District 2 (Gainesville)
Hall County Health Department
1290 Athens Street
Gainesville, GA 30507

Alexandra Perez 770-535-5801
Fax 770-535-5742
Monday - Friday 8:00 am - 5:00 pm

Counties include: Banks, Dawson, Forsyth, Franklin, Habersham, Hall, Hart, Lumpkin, Rabun, Stephens, Towns, Union, and White

District 3-1 (Cobb-Douglas)
Positive Impact Health Centers - Marietta
1650 County Services Parkway SW
Marietta, Georgia 30008-4010

Dominique Brown-Nelson 770-738-8555
Monday - Friday 8:00 am - 5:00 pm

Counties include: Cobb, and Douglas

District 3-3 (Clayton)
Clayton County Board of Health
34 Upper Riverdale Rd, Suite 200
Riverdale, GA 30297

Hawa Kone	678-479-2209
Front Desk	678-610-7640
Monday - Friday	8:00 am - 5:00 pm
Primary care office hours by appointment:	
Monday - Friday	9:00 am - 5:00 pm

Counties include: Clayton

District 3-4 (Gwinnett)
Positive Impact Health Center
3350 Breckenridge Blvd., Suite 200
Duluth, Ga. 30096-7612

Karen Cross	678-990-6415
Mon. - Thurs.	8:30 am - 5:00 pm
Friday	8:30 am – 1:00 pm
1st Saturday	8:30 am - 12:30 pm

Counties include: Gwinnett, Rockdale, and Newton

District 4 (LaGrange)
AID Atlanta Newnan
770 Greison Trail
Suite H
Newnan, GA 30263

Tamakio Patterson	770-252-5418
Monday - Friday	8:00 am - 5:00 pm

Counties include: Butts, Carroll, Coweta, Fayette, Heard, Henry, Lamar, Meriwether, Pike, Spalding, Troup, and Upson

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District 5-1 (Dublin)
South Central Health District
103 Mercer Drive, Suite B
Dublin, Georgia 30121

Malela Rozier	478-274-3012
Mon./Tues./Weds.	8:00 am - 4:30 pm
Thursday	8:00 am - 7:00 pm
Friday	8:00 am - 1:30 pm

Counties include: Bleckley, Dodge, Johnson, Laurens, Montgomery, Pulaski, Telfair, Treutlen, Wheeler, and Wilcox

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District 5-2 (Macon)
COMPASS Cares
180 Emery Highway
Macon, GA 31217

Erin Wust	478-464-0612
Mon./Weds./Thur.	7:00 am - 5:00 pm
Tuesday	7:00 am - 7:00 pm
Friday	7:00 am - 11:30 am

Counties include: Baldwin, Bibb*, Crawford, Hancock, Houston, Jasper, Jones, Monroe, Peach, Putnam, Twiggs, Washington, and Wilkinson

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District 6 (Augusta)
East Central Health District
1916 North Leg Road
Augusta, GA 30909

Brandon Dykes	706-667-4340

*Please call for specific clinic hours.

Christ Community Health Services
Augusta Inc.
127 Telfair Street
Augusta, GA 30901

Ryan Quiller 706-396-1480
Monday - Friday 8:00 am - 5:00 pm

Counties include: Burke, Columbia, Emanuel, Glascock, Jefferson, Jenkins, Lincoln, McDuffie, Richmond, Screven, Taliaferro, Warren, and Wilkes

District 7 (Columbus)

Columbus Health Department
2100 Comer Avenue
Columbus, GA 31904

Cathy Graves 706-321-6420
Monday - Friday 8:00 am - 5:00 pm

Sumter County Health Department
1601 N. MLK Jr. Blvd.
Americus, GA 31719

Kimberly Redford 229-931-2514
8:00 am - 5:00 pm on:
1st Tuesday and Thursday of the month
2nd and 3rd Tues. and Weds. of the month

Crisp County Health Department
111 24th Street East
Cordele, GA 31015

Kimberly Redford 229-276-2680 or
229-931-2514
9:00 am - 4:00 pm on:
1st & 4th Wednesday of the month
4th Tuesday of the month
1st, 2nd, 3rd & 4th Friday of the month
Friday hours of operation: 9:00 am - 3:00 pm

Randolph County Health Department
410 N. Webster St
Cuthbert, GA 39840

Kimberly Redford 229-732-2414 or
229-931-2514
9:30 am - 3:00 pm on:
2nd Thursday of the month

Counties include: Chattahoochee, Clay, Crisp, Dooly, Harris, Macon, Muscogee, Marion, Quitman, Randolph, Schley, Stewart, Sumter, Talbot, Taylor, and Webster

District 8-1 (Valdosta)

Adult Health Promotion Clinic (Valdosta)
601 N. Lee St.
Valdosta, GA 31601

Teresa Hritz 229-245-8711, ext 239
Althea Daniels 229-245-8711, ext 288
Clinic Receptionist 229-247-8025
Monday – Thursday 8:00 am - 5:00 pm
Fridays 8:00 am - 2:30 pm

Adult Health Promotion Clinic (Tifton)
305 E. 12th St.
Tifton, GA 31794

Counties include: Ben Hill, Berrien, Brooks, Cook, Echols, Irwin, Lanier, Lowndes, Tift, and Turner

Teresa Hritz	229-245-8711, ext 239
Althea Daniels	229-245-8711, ext 288
Clinic Receptionist	229-391-9281
Monday – Thurs.	8:00 am - 5:00 pm
Fridays	8:00 am - 2:30 pm

District 8-2 (Albany)
Thomasville Office
14540 US. 19 South; Suite 1,
Thomasville, GA 31758

Kirstern James 229-225-3996
Zeenat Turner 229-225-4392
1st and 3rd Friday (Clinical Services)
Tues – Thurs (Case Management Services)
9:00 am - 1:00 pm

Albany Office
1710 S. Slappey Blvd.
Albany Ga. 31706

Remy Hutchins 229-638-6428
Monday – Friday 7:30 am - 6:00 pm
*Clients are seen for case management and ADAP services only. Clinical services are not provided in the Albany office

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Rural Clinic
2202 E. Oglethorpe Blvd.
Albany, GA 31705
(Part B Subcontractors for Thomasville Clinic)

Dawn Robinson	229-431-1423
Monday - Friday	8:30 am - 5:00 pm

Counties include: Baker, Calhoun, Colquitt, Dougherty, Decatur, Early, Grady, Lee, Miller, Mitchell, Seminole, Terrell, Thomas, and Worth

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District 9-1 (Savannah-Brunswick)
Chatham CARE Center
107 B Fahm Street
Savannah GA 31401

Donna Corey	912-651-2253
Monday - Friday	7:30 am - 6:00 pm

Glynn CARE Center
2747 4th St.
Brunswick, GA 31520

Mallory Chappell	912-264-3236
Monday - Weds.	8:00 am - 5:00 pm
Thursday	8:00 am - 7:00 pm
Friday	8:00 am - 12:00 pm

Liberty CARE Center
1113 E. Oglethorpe Hwy.
Hinesville, GA 31313

Counties include: Bryan, Camden, Chatham, Effingham, Glynn, Liberty, Long, and McIntosh

Mallory Chappell	912-264-3236
Clinic Directly	912-876-5085 or 1-877-221-6959

Mon. - Wed. by appointment only

District 9-2 (Waycross)

Bulloch Wellness Center 3 West Altman Street Statesboro, GA 30458	Shelby Freeman Monday - Friday	912-764-2402 or 1-800-796-6213 8:00 am - 5:00 pm
Coffee Wellness Center 1003 Shirley Avenue Douglas, GA 31533-2123	Amanda Coffee Monday - Friday	912-389-4586 or 1-866-808-7828 8:00 am - 5:00 pm
Toombs Wellness Center 714 North West Broad St. Lyons, GA 30436	Shelby Freeman 2nd and 4th Friday	912-764-2402 or 912-526-6488* (*Only on clinic days) 8:00 am - 5:00 pm
Ware Wellness Center 1123 Church St. Waycross, GA 31501	Amanda Coffee Once a month	912-389-4586 9:00 am - 4:00 pm

Counties include: Appling, Atkinson, Bacon, Brantley, Bulloch, Candler, Charlton, Clinch, Coffee, Evans, Jeff Davis, Pierce, Tattnall, Toombs, Ware, and Wayne

District 10 (Athens)

Specialty Care Clinic Clarke County Health Dept. 700 Sunset Drive, Suite 501 Athens, GA 30606	Donald Eisman Mon./Wed./Thurs. Tuesday Friday	706-425-2997 or 1-877-807-6260 8:00 am - 5:00 pm 8:00 am - 7:00 pm 8:00 am - 2:00 pm

Counties include: Barrow, Clarke, Elbert, Greene, Jackson, Madison, Morgan, Oconee, Oglethorpe, and Walton

Appendix B: ADAP/HICP Enrollment Sites

District/ Agency	ADAP/HICP Contact	District/Agency Director
0-5 AID Atlanta AID Atlanta Health Center 1605 Peachtree Street, NE Atlanta, GA 30309	**Kenneth Clement,** Client Services Program Manager (404) 870-7744 Kenneth.clement@aidatlanta.org **Sydni Edwards** 404-870-7729 Sydni.Edwards@aidatlanta.org **Antonique Hughes** 404-870-7717 Antonique.Hughes@aidatlanta.org **Aijalon Peyton** 470-283-7349 ext. 1704 Aijalon.Peyton@aidshealth.org **Front Desk line:** (404) 870-7700 (800) 551-2728	**Jenetter Richburg,** Director (404) 870-7794 jenetter.richburg@aidatlanta.org **Delma Gomez-Adisa,** Director of AID Atlanta AHF (404) 870-7743 delma.gomezadisa@aidshealth.org **Nicole Roebuck,** Executive Director 770-870-7724 nicole.roebuck@aidatlanta.org PART A-Client Services Director
0-7 Grady IDP Grady Health Systems, I.D.P. 341 Ponce de Leon Avenue Atlanta, GA 30308 **Grady IDP HICP**	**Kaylene Shipp** (404) 616-9291 kshipp@gmh.edu **Patricia Dabney** (404) 616-9739 pdabney@gmh.edu **LaConteau Bonner** (404) 616-0432 lbonner@gmh.edu **William Curry** (404) 616-0465 wcurry@gmh.edu **Meron Asrat** (404) 616-9558 masrat@gmh.edu **Pharmacy Fax:** (404) 616-9777 **D. Chanel Scott-Dixon** (404) 616-9861 dcscottdixon@gmh.edu **Stacy Bolling** (404) 616-6121 sbolling@gmh.edu **D. Marie Howard** (404) 616-6300 dmhoward@gmh.edu	**Lisa Roland**, IDP Director (404) 616-9785 lroland@gmh.edu **Alton Condra**, Pharmacy Supervisor (404) 616-9783 acondra@gmh.edu **Kay Woodson**, Pharmacy Manager (404) 616-2896 kwoodson@gmh.edu **Tonya Rankin** (404) 616-9715 trankins@gmh.edu **Family and Youth Clinic** **Shellie Bigelow**, Social Work Supervisor (404) 616-6243 sbigelow@gmh.edu **Lisa Curtin** (404) 616-9795 lcurtin@gmh.edu **Antoine Jones** (404) 616-9789 Ajones12@gmh.edu

District/ Agency	ADAP/HICP Contact	District/Agency Director
	Taj Woods (404) 616-0660 tkwoods@gmh.edu **Ryan Woodbury** (404) 616-6302 rawoodbury@gmh.edu **Kizzy Champion-Massey** (404) 616-1176 kchampionmas@gmh.edu **Kristin Lee** **Care Resource Coordinator** knlee@gmh.edu (404) 616-2426 **Fax:** 404-489-6017 **Care Resource Coordinator** **Main phone line:** 404-616-0181 **Main phone line:** (404) 616-9776 **Fax:** (404) 616-9790	
1-0 Athens Specialty Care Clinic 700 Sunset Drive Suite 501 Athens, GA 30606	**Jacque Hancock** (706) 425-2938 Jacque.hancock@dph.ga.gov **Andrea Carey** (706) 552-4539 andrea.carey@dph.ga.gov **Main phone line:** (706) 425-2935 **Fax:** (706) 425-2936	**Donald Eisman** (706) 425-2997 donald.eisman@dph.ga.gov
1-1 Rome Northwest Georgia Specialty Care 16 East 12th Street, Suite 202 Rome, GA 30161	**Amanda Loveless** (706) 295-6701 amanda.loveless@dph.ga.gov **Jocelyn Carpenter** (706) 295-6701 jocelyn.carpenter@dph.ga.gov **Katrina Harber** (706) 295-6701 Katrina.Harber@dph.ga.gov **Fax:** (706) 295-6697	**Janet Eberhart** (706) 802-5444 janet.eberhart@dph.ga.gov

District/ Agency	ADAP/HICP Contact	District/Agency Director
1-2 Dalton The Living Bridge Center 1200 West Waugh Street, Suite A Dalton, GA 30720 The Living Bridge Center-South 130 Riverstone Terrace Suite 102 Canton, GA 30114	**Paige Wilson** (706) 281-2205 paige.wilson@dph.ga.gov **Main phone line**: (706) 281-2360 **Fax:** (706) 281-2390 **Pamela Baker** (470) 863-5700 ext. 19556 pamela.baker@dph.ga.gov **Fax:** (470) 863-5701	**Jeff Vollman**, Director (706) 281-2360 jeffery.vollman@dph.ga.gov
2-0 Gainesville Hall County Health Department 1280 Athens Street Gainesville, GA 30507	**Alexandra Perez** (770) 535-5801 alexandra.perez@dph.ga.gov **Esperanza Barajas** (770) 535-5801 esperanza.barajas@dph.ga.gov **Amber Bell**, Infectious Disease Coordinator Cell: (770) 519-1207 amber.bell@dph.ga.gov **Fax:** (770) 535-5743	**Zachary Taylor, MD,** District Health Director (770)-535-5743 Zachary.taylor@dph.ga.gov **Alan Satterfield RN**, Nurse Manager (770) 531-5607 Alan.satterfield@dph.ga.gov **Rebecca Moges-Banks,** Ryan White Program Coordinator (770) 531-5872 renecca.moges-banks@dph.ga.gov
2-2 Saint Joseph's Mercy Care 424 Decatur Street, SE Atlanta, GA 30312	**Precious Jackson** (678) 843-8631 Precious.Jackson@aidatlanta.org **Christina Williamson** (678) 843-8535 christina.williamson@mercyatlanta.org **Fax:** (678) 843-8601	**Patricia Parsons**, Manager (678) 843-8930 pparsons@mercyatlanta.org
3-1 Cobb &Douglas/ Positive IMPACT Capstone Health at Cobb & Douglas Public Health 1650 County Services Parkway Marietta, GA 30008-4009	**Melanie Jones** (770) 514-2398 melanie.jones@pihcga.org **Linda Beauford** (678) 990-6427 Linda.beauford@pihcga.org **Main phone line:** (770) 514-2464 **Fax:** (770) 514-2806	**Karen Cross,** Director of Client Services (678) 990-6415 karen.cross@pihcga.org

District/ Agency	ADAP/HICP Contact	District/Agency Director
3-2 Fulton Fulton County Board of Health 10 Park Place South, SE, Suite 554 Atlanta, GA 30303 186 Sunset Ave NW Atlanta, GA 30314	**Juan Dandridge** (404) 613-1308 juan.dandridge@fultoncountyga.gov **Douglas Bell** (404) 613-1564 douglas.bell@fultoncountyga.gov **Fax:** (404) 612-3443	**Reginald Goddard,** Health Coordinator (404) 613-1457 reginald.goddard@fultoncountyga.gov **Stacey Coachman,** Program Administrator (404) 613-1487 Stacey.coachman@fultoncountyga.gov
3-3 Clayton Clayton County Board of Health 34 Upper Riverdale Rd, Ste. 200 Riverdale, GA 30296	**Brenda Johnson** (678) 479-2202 brenda.johnson@dph.ga.gov **Main phone line:** (678) 610-7199 **Fax:** (770) 892-9095	**Hawa Kone** Ryan White Program Coordinator (678) 479-2209 Fax: (770) 603-4178 Hawa.kone@dph.ga.gov
3-4 Positive Impact Health Centers 3350 Breckinridge Blvd Ste. 200 Duluth Ga. 30096 Serving: Gwinnett, DeKalb, Cobb and Douglas Centers Located in **Decatur**, **Duluth**, and **Marietta** *Direct Line: 770-738-8523* **Duluth Center Main** 770-962-8396 **Decatur Center Main** 404-589-9040 **Marietta Center Main** 770-514-2464	**Linda Beauford (Gwinnett)** (678) 990-6427 Linda.beauford@pihcga.org **Fax:** (678) 990-6429	**Karen Cross,** LCSW (678) 990-6415 karen.cross@pihcga.org
3-5 DeKalb DeKalb County Board of Health 445 Winn Way, P.O. Box 987 Decatur, GA 30031	**ArShonye Henderson** (404) 508-7804 arshonye.henderson@dph.ga.gov **Dr. Christopher Marine** (404) 508-7881 christopher.marine@dph.ga.gov **Fax:** (404) 297-7231	**Sentayehu Bedane** Program Coordinator (404) 508-7940 sentayehu.bedane@dph.ga.gov

District/ Agency	ADAP/HICP Contact	District/Agency Director
3-6 AIDS Healthcare Foundation AHF 5700 Hillandale Drive, Suite 100 Lithonia, GA 30058 AHF-Midtown 735 Piedmont Ave NE Atlanta, GA 30308	**Lithonia Location** **Connie Evans** (770) 593-6684 connie.evans@aidshealth.org **Tyshemala Singleton** (770) 593-6684 tyshemala.singleton@ahf.org **Midtown Location** (404) 588-4680 **Stephanie Williams (Mid-town)** (404) 588-4680 stephanie.williams@aidshealth.org **Ellie Sender (Mid-town)** (404) 588-4680 ellie.sender@ahf.org **Fax:** (770) 593-8166	**Katherine Barbera**-Practice Manager-(Mid-town) (404) 588-4680 katherine.barbera@aidshealth.org **Suzanne Lipe,** Pharmacy Manager (770) 808-3705 suzanne.lipe@aidshealth.org **Fax:** (770) 808-4432
3-8 Southside Medical Center SMC 1046 Ridge Ave SW Atlanta, GA 30315	**Leah Pinholster** (404) 564-6829 lpinholster@smcmed.com **Fax:** (404) 564-6982	**Andrea Steward,** Manager (404) 564-6860 asteward@smcmed.com
4-0 LaGrange/Griffin AID Atlanta Newnan Healthcare Center 6 Jefferson Parkway, Suite C Newnan, GA 30263	**Bneikia Robinson** (770) 252-5418 bneikia.robinson@aidatlanta.org **Fax:** (770) 252-5417	**Tamakio Patterson,** Office Admin/Program Manager (770) 252-5418 Tamakio.patterson@aidatlanta.org **Nicole Roebuck,** Executive Director 770-870-7724 nicole.roebuck@aidatlanta.org
5-1 Dublin South Central Health District 2121 B. Bellevue Road Dublin, GA 31021	**Annie Brown** (478) 274-7677 annie.brown@dph.ga.gov **Fax:** (478) 274-7948 **Fax:** (478) 274-7719	**Malela Rozier,** HIV Coordinator (478) 274-3012 malela.rozier@dph.ga.gov
5-2 Macon The HOPE Center 180 Emery Hwy Macon, GA 31216	**Michelle Blount** (478) 464-0612 michelle.blount@dph.ga.gov **Erin Wust, RN, BSN** (478) 464-0612 Erin.Wust@dph.ga.gov	**Dale Wrigley**, Program Director The Hope Center (478) 464-0612 ext. 104 dale.wrigley@dph.ga.gov
6-0 Augusta 1916 North Leg Road Building H Augusta, Georgia 30909	**Yanza Collins** (706) 667-4731 Yanza.collins@dph.ga.gov	**Jonathan Adriano,** Interim Program Director (706) 667-4931 Jonathan.adriano@dph.ga.gov

District/ Agency	ADAP/HICP Contact	District/Agency Director
Christ Community Health Services 127 Telfair Street Augusta, GA 30901	**Jeanette Neal** (706) 667-4829 Jeanette.neal@dph.ga.gov **Fax:** (706) 667-4728 **Ryan Quiller,** CMA (706) 396-1480 rquiller@cchaugusta.org **Fax:** (706) 922-0604	**Brandon Dykes**, HIV Program Manager (706) 667-4340 brandon.dykes@dph.ga.gov
6-1 Augusta University 1120 15th Street, BP2511 Augusta, GA 30912	**Erin Gilstrap** (706) 721-9521 ergilstrap@augusta.edu **Phyllis Walker** (706) 721-9534 phwalker@augusta.edu **Rebekah Tesch** (706) 721-3763 rtesch@augusta.edu **Capus Barnett** (706) 721-9545 Cbarnet3@augusta.edu **Fax:** (706) 446-0209	**Kerstin Carswell,** Ryan White Program Clinical Support Manager (706) 721-2236 kcarswell@augusta.edu
7-0 Columbus District Clinical Services 2100 Comer Ave Columbus, GA 31902 **District Clinical Services** P.O. Box 865 1601 N. MLK Jr Blvd, Suite 100 Americus, GA 31709	**Rika Vines** (706) 321-6411 rika.vines@dph.ga.gov **Crystal McCants** (706) 321-6300 crystal.mccants@dph.ga.gov **Fax: (706) 321-6428** **Kathryn Arnold** (229) 931-2515 kathryn.arnold@dph.ga.gov **Fax:** (229) 931-7017	**Cathy Graves**, RN Program Coordinator (706) 321-6420 cathy.graves@dph.ga.gov
8-1 Valdosta **Adult Health Promotion Clinic-South** 601 North Lee Street Valdosta, GA 31602 **Adult Health Promotion Clinic- North** 305 E. 12th Street	**Jennifer J. Bradley (Valdosta)** (229) 245-8711 ext. 231 jennifer.bradley@dph.ga.gov **Main phone line:** (229) 247-8025 **Fax:** (229) 245-8432 **LaShawn Graham (Tifton)** (229) 391-9281, ext. 152 lashawn.graham@dph.ga.gov	**Teresa Hritz, RN** Infections Disease Coordinator (229) 245-8711, ext. 239 teresa.hritz@dph.ga.gov

District/ Agency	ADAP/HICP Contact	District/Agency Director
Tifton, GA 31794	**Main phone line:** (229) 391-9281 **Fax:** (229) 391-9857	
8-2 Albany The Rural Clinic 2202 E. Oglethorpe Albany, GA 31705 **New Beginnings Program** P.O. Box 4935 Albany, Georgia 31706	**LaToya Robinson** (229) 430-4090 latoya.robinson@dph.ga.gov **Tonya High** (229) 430-5140 Tonya.high@dph.ga.gov **Fax:** (229) 430-5142	**Remy Hutchins,** ACID Coordinator (229) 430-7870 remy.hutchins@dph.ga.gov
9-1 Savannah/Brunswick Chatham CARE Center 107 B Fahm Street Savannah, GA 31401 **Liberty CARE Center** 1113 E Oglethorpe Hwy Hinesville, GA 31313 **Glynn CARE Center** 2747 4th Street Brunswick, GA 31520	**Tenell Davis** (912) 651-1986 (Chatham) (912) 651-2319 (Liberty) tenell.davis@dph.ga.gov **Terresa Pinkston** (912) 651-2319(Chatham) (912) 651-2319 (Liberty) Terresa.Pinkston@dph.ga.gov **Main Line:** (912) 651-2253 **(Chatham)** **Fax:** (912) 651-2365 **(Chatham)** (912) 876-2037 **(Liberty)** **Danielle Rhett** (912) 264-3236 (Glynn) danielle.rhett@dph.ga.gov **Fax:** (912) 264-0813 **(Glynn)**	**Susan Alt**, **BSN, ACRN, Director** (912) 651-0995 susan.alt@dph.ga.gov
9-2 Waycross 1115 Church Street, Suite A Waycross, GA 31501 **Waycross Wellness Centers:** **Bulloch Wellness Center** 3 West Altman Street Statesboro, GA 30458 **Coffee County Wellness** 1003 Shirley Avenue Douglas, GA 315 **Toombs Wellness Center** 714 North West Broad Street Lyons, GA 30436 **Ware Wellness Center** 604 Riverside Ave Waycross, GA 31501	**Sabrina Sheppard (Bulloch Wellness)** (912) 764-2402 sabrina.sheppard@dph.ga.gov **Fax:** (912) 764-5561 **Barbara Bragg (Bulloch Wellness)** (912) 764-2402 barbara.bragg@dph.ga.gov **Fax:** (912)764-5561 **Sarah Womble (Bulloch & Toombs Wellness)** (912) 764-2402 sarah.womble@dph.ga.gov **Fax:** (912) 764-5561 **Carmen Day (Coffee Wellness)** (912) 389-4586	**Bulloch Wellness Center:** **Shelby Freeman,** MPH, MSW (912) 764-2402 shelby.freeman@dph.ga.gov

District/ Agency	ADAP/HICP Contact	District/Agency Director
	carmen.day@dph.ga.gov **Fax:** (912) 389-4590 **Genevieve Gardner (Coffee Wellness)** (912) 389-4586 (1-866)808-7828 Genevieve.Gardner@dph.ga.gov **Hydie Lewis (Coffee Wellness)** (912) 389-4586 hydie.lewis@dph.ga.gov **Fax:** (912) 389-4590	
9-9 Emory I.D. Clinic 550 Peachtree Street, NE Atlanta, GA 30308	**Katharine Heika** (404) 686-3320 kwhisna@emory.edu **Aleksandra (Ola) Lissowska** (404) 686-3682 alissow@emory.edu **Bertha Jackson** (404) 686-3391 Bertha.jackson@emory.edu **Shalanda Anderson (ADAP)** (404) 686-3337 Shalanda.shunta.anderson@emory.edu **Fax:** (404) 686-5723	**Deborah Downey, LCSW, Supervisor** (404) 686-7814 deborah.downey@emory.edu **Fax: (404) 686-2810**

Appendix C: Justification for Order of Stop Gap Medications Worksheet

Justification for Order of Stop Gap Medications

District: _____
Clinic: _____
Month: _____

Instructions:
This worksheet is to be used as the justification for ordering Stop-Gap Medications. ***The worksheet must be submitted to the*** appropriate contact person at the ***Georgia Department of Public Health Ryan White Part B Program before any medication orders are submitted to Cardinal***. *Orders for medications can only be placed after approval from the state office.*

The client CAREWare URN will be used as the identifier for this worksheet. The CAREWare URN must also be used to identify clients in the monthly stop gap medication logs. One line should be used per client.

Client CAREWare URN	Is the client eligible for Part B/ ADAP? (Y/N)	Has the ADAP application been completed and submitted? (Y/N)	Date of ADAP application submission	Has the client been referred to a patient assistance program (PAPs)? (Y/N)	Was the client able to get assistance from the PAP? (Y/N)	Which of the following criteria does the client meet? (list all that apply): • Pregnancy • CD4 count below 200 cells/mm3 • History of an AIDS defining illness • Co-morbid conditions (e.g. HIV-associated dementia, HIV-associated nephropathy, Hepatitis B virus co-infection)• Acute HIV infection	Name of Drug/Drugs to be provided to the client (please list all)	Quantity to be dispensed (please list for all medications)

For Ryan White Part B Program State Office Staff Only:

Approved by: _____ **Date Approved:** _____

Denied by: _____ **Date Denied:** _____

Appendix D: Medication Dispensing Log

Medication Dispensing Log

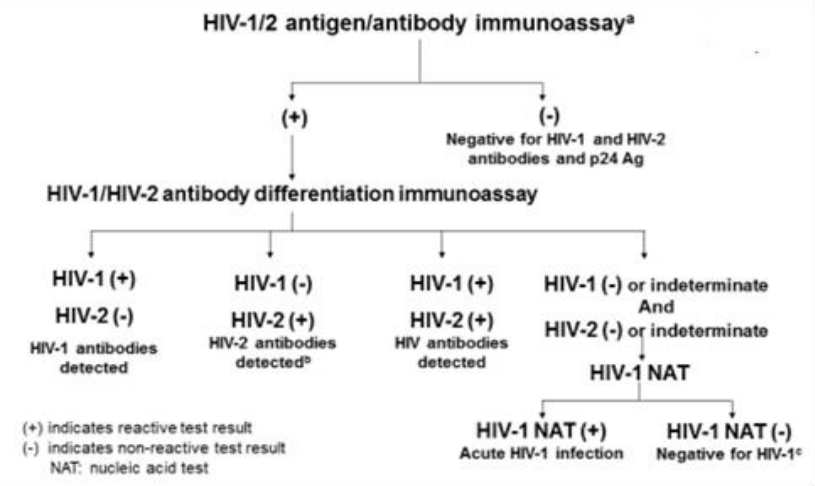
Clinic Name_____ Month_____

Client Identifier	Name of Drug	Strength	Quantity Dispensed	Date Dispensed	Exp. Date

RWB Stop-Gap Medication
11/2012

Appendix E: HIV Testing Algorithm

Recommended Laboratory HIV Testing Algorithm for Serum or Plasma Specimens



1. Laboratories should conduct initial testing for HIV with an FDA-approved antigen/antibody immunoassay that detects HIV-1 and HIV-2 antibodies and HIV-1 p24 antigen to test for established HIV-1 and HIV-2 infection and for acute HIV-1 infection, respectively. No further testing is required for specimens that are non-reactive on the initial immunoassay. However, if there is a possibility of very early infection leading to a non-reactive initial antigen/antibody immunoassay, such as when recent HIV exposure is suspected or reported, then conduct an HIV-1 nucleic acid test (NAT), or request a new specimen and repeat the algorithm according to CDC guidance.

2. Specimens with a reactive antigen/antibody immunoassay result (or repeatedly reactive, if repeat testing is recommended by the manufacturer or required by regulatory authorities) should be tested with an FDA-approved supplemental antibody immunoassay that differentiates HIV-1 antibodies from HIV-2 antibodies. Reactive results on the initial antigen/antibody immunoassay and the HIV-1/HIV-2 antibody differentiation immunoassay should be interpreted as positive for HIV-1 antibodies, HIV-2 antibodies, or HIV antibodies, un-typable (undifferentiated).

3. Specimens that are reactive on the initial antigen/antibody immunoassay and non-reactive or indeterminate on the HIV-1/HIV-2 antibody differentiation immunoassay should be tested with an FDA-approved HIV-1 NAT.
    - A reactive HIV-1 NAT result and non-reactive or indeterminate HIV-1/HIV-2 antibody differentiation immunoassay result indicates laboratory evidence of acute HIV-1 infection.
    - A negative HIV-1 NAT result and non-reactive or HIV-1 indeterminate antibody differentiation immunoassay result indicates an HIV-1 false-positive result on the initial immunoassay.
    - A negative HIV-1 NAT result and repeatedly HIV-2 indeterminate or HIV indeterminate antibody differentiation immunoassay result should be referred for testing with a different validated supplemental HIV-2 test (antibody test or NAT) or repeat the algorithm in 2 to 4 weeks, starting with an antigen/antibody immunoassay.

4. Laboratories should use this same testing algorithm, beginning with an antigen/antibody immunoassay on all serum or plasma specimens submitted for testing after a preliminary positive result from any rapid HIV test conducted in a CLIA-waived setting.

Report results from the HIV diagnostic testing algorithm to persons ordering HIV tests and public health authorities

Reporting results from the HIV laboratory diagnostic algorithm for use with serum and plasma specimens

Test Outcomes	Test Sequence			Final Algorithm Interpretation	Provider Interpretation	Further Actions
	Step 1	Step 2	Step 3			
	HIV-1/HIV-2 Ag/Ab	HIV-1/HIV-2 Antibody Differentiation	HIV-1 NAT		Report sample as:	
	Non-reactive	N/A	N/A	HIV-1 antigen & HIV-1/HIV-2 antibodies were not detected. No laboratory evidence of HIV infection	HIV Negative	If recent HIV exposure is suspected or reported, conduct HIV-1 NAT or request a new specimen and repeat the algorithm according to CDC guidance.
	Reactive	HIV-1 Positive	N/A	Positive for HIV-1 antibodies. Laboratory evidence of HIV-1 infection is present	HIV-1 Positive	Link patient to HIV medical care and provide appropriate prevention counseling.
	Reactive	HIV-2 Positive	N/A	Positive for HIV-2 antibodies. Laboratory evidence of HIV-2 infection is present	HIV-2 Positive	
	Reactive	HIV-2 Positive with HIV-1 cross reactivity	N/A	Positive for HIV-2 antibodies. Laboratory evidence of HIV-2 infection is present	HIV-2 Positive Result distinct from HIV positive un-typable (undifferentiated)	
	Reactive	HIV Positive un-typable (undifferentiated)	N/A	Positive for HIV-1 and HIV-2 antibodies. Laboratory evidence of HIV-1 and/or HIV-2 infection is present	HIV Positive	Link patient to HIV medical care and provide appropriate prevention counseling. Provider may consider additional testing for HIV-1 RNA or DNA and HIV-2 RNA or DNA to verify or rule out HIV-1/HIV-2 dual infection. Request additional specimen if original specimen volume is insufficient.
	Reactive	HIV-1 indeterminate, HIV-2 indeterminate, HIV indeterminate	Detected	Positive for HIV-1. Laboratory evidence of HIV-1 infection consistent with an acute HIV-1 infection	**Acute** HIV-1 Positive	Link patient to HIV medical care and provide appropriate prevention counseling immediately to expedite prevention practices.
	Reactive	HIV-1 indeterminate	Not detected	HIV-1 antibodies were not confirmed, and HIV-1 RNA was not detected	HIV Negative	If recent HIV exposure is suspected or reported, request a new specimen and repeat the algorithm according to CDC guidance.
	Reactive	HIV-2 indeterminate	Not detected	HIV antibodies were not confirmed, and HIV-1 RNA was not detected. HIV-2 inconclusive	HIV-1 Negative, HIV-2 Inconclusive	Refer sample for testing with a different validated supplemental HIV-2 test (antibody test or NAT) if available. Alternatively, re-draw and repeat algorithm in 2-4 weeks to assess HIV-2 infection.
	Reactive	HIV indeterminate	Not detected	HIV-1 antibodies were not confirmed, and HIV-1 RNA was not detected. HIV-2 inconclusive	HIV-1 Negative, HIV-2 Inconclusive	
	Reactive	Negative	Detected	Positive for HIV-1. Laboratory evidence of HIV-1 infection consistent with an acute HIV-1 infection	**Acute** HIV-1 Positive	Link patient to HIV medical care and provide appropriate prevention counseling immediately to expedite prevention practices.
	Reactive	Negative	Not detected	HIV antibodies were not confirmed, and HIV-1 RNA was not detected	HIV Negative	If recent HIV exposure is suspected or reported, request a new specimen and repeat the algorithm according to CDC guidance.
	Reactive	Negative or Indeterminate	Invalid or Not performed	Inconclusive	Inconclusive	Request an additional specimen and repeat the algorithm. Ensure HIV-1 NAT is performed, if indicated by results of HIV-1/HIV-2 Ag/Ab and HIV-1/HIV-2 Ab differentiation.

Appendix F: Case Report Form

GEORGIA ADULT HIV/AIDS CONFIDENTIAL CASE REPORT FORM
(Patients ≥ 13 years of age at time of diagnosis)

Mail completed form to: Georgia Department of Public Health, Epidemiology Section P.O. Box 2107 Atlanta, GA 30301
For additional information: Phone: 1-800-827-9769 or visit our website at http://health.state.ga.us/epi/hivaids

All health care providers diagnosing and/or providing care to a patient with HIV are obligated to report using Georgia HIV/AIDS Case Report. Case reports should be completed within seven (7) days after diagnosing or providing care to a patient with HIV/AIDS. Providers are required to submit reports on any patient new to his or her care, regardless if they have previously received care elsewhere.

Patients <13 should be reported on a Pediatric Case Report Form (https://dph.georgia.gov/hivaids-case-reporting)

Patient Identification (record all dates as mm/dd/yyyy) *Information NOT transmitted to CDC

*First Name	*Middle Name	*Last Name	Last Name Soundex
Alternate Name Type (ex: Alias, Married)	*First Name	*Middle Name	*Last Name
Address Type ☐ Residential ☐ Bad address ☐ Correctional facility ☐ Foster home ☐ Homeless ☐ Postal ☐ Shelter ☐ Temporary	*Current Address, Street		Address Date __ __ /__ __ /__ __ __ __
*Phone ( )	City	County	State/Country	*ZIP Code
*Medical Record Number	*Other ID Type	*Number	

Facility Providing Information (record all dates as mm/dd/yyyy)

Facility Name			*Phone ( )
*Street Address			
City	County	State/Country	*ZIP Code
Facility Type	*Inpatient*: ☐ Hospital ☐ Other, specify _____	*Outpatient*: ☐ Private physician's office ☐ Adult HIV clinic ☐ Other, specify _____	*Screening, Diagnostic, Referral Agency*: ☐ CTS ☐ STD clinic ☐ Other, specify _____	*Other Facility*: ☐ Emergency room ☐ Laboratory ☐ Corrections ☐ Unknown ☐ Other, specify _____
Date Form Completed __ __ /__ __ /__ __ __ __	*Person Completing Form		*Phone ( )

Patient Demographics (record all dates as mm/dd/yyyy)

Sex Assigned at Birth ☐ Male ☐ Female ☐ Unknown	Country of Birth ☐ US ☐ Other/US dependency (please specify) _____		
Date of Birth __ __ /__ __ /__ __ __ __	Alias Date of Birth __ __ /__ __ /__ __ __ __		
Vital Status ☐ 1-Alive ☐ 2-Dead	Date of Death __ __ /__ __ /__ __ __ __	State of Death	
Current Gender Identity ☐ Male ☐ Female ☐ Transgender male-to-female (MTF) ☐ Transgender female-to-male (FTM) ☐ Unknown ☐ Additional gender identity (specify) _____			
Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown		Expanded Ethnicity	
Race (check all that apply) ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Unknown		Expanded Race	

Residence at Diagnosis (add additional addresses in Comments) (record all dates as mm/dd/yyyy)

Address Type (check all that apply to address below) ☐ Residence at HIV diagnosis ☐ Residence at stage 3 (AIDS) diagnosis ☐ Check if SAME as current address			
*Street Address			
City	County	State/Country	*ZIP Code

CDC 50.42A Rev. 02/2018 (Page 1 of 4) —ADULT HIV CONFIDENTIAL CASE REPORT—

Facility of Diagnosis (add additional facilities in Comments)

Diagnosis Type (check all that apply to facility below) ☐ HIV ☐ Stage 3 (AIDS) ☐ Check if SAME as facility providing information			
Facility Name			***Phone** ( )
***Street Address**			
City	**County**	**State/Country**	***ZIP Code**
Facility Type *Inpatient*: ☐ Hospital ☐ Other, specify _____	*Outpatient*: ☐ Private physician's office ☐ Adult HIV clinic ☐ Other, specify _____	*Screening, Diagnostic, Referral Agency*: ☐ CTS ☐ STD clinic ☐ Other, specify _____	*Other Facility*: ☐ Emergency room ☐ Laboratory ☐ Corrections ☐ Unknown ☐ Other, specify _____
***Provider Name**	***Provider Phone** ( )	**Specialty**	

Patient History (respond to all questions) (record all dates as mm/dd/yyyy) ☐ **Pediatric Risk (please enter in Comments)**

After 1977 and before the earliest known diagnosis of HIV infection, this patient had:	
Sex with male	☐ Yes ☐ No ☐ Unknown
Sex with female	☐ Yes ☐ No ☐ Unknown
Injected nonprescription drugs	☐ Yes ☐ No ☐ Unknown
Received clotting factor for hemophilia/coagulation disorder Specify clotting factor: Date received __ __/__ __/__ __ __ __	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL relations with any of the following:	
HETEROSEXUAL contact with intravenous/injection drug user	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with bisexual male	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with person with hemophilia/coagulation disorder with documented HIV infection	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with transfusion recipient with documented HIV infection	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with transplant recipient with documented HIV infection	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with person with documented HIV infection, risk not specified	☐ Yes ☐ No ☐ Unknown
Received transfusion of blood/blood components (other than clotting factor) (document reason in Comments)	☐ Yes ☐ No ☐ Unknown
First date received __ __/__ __/__ __ __ __ Last date received __ __/__ __/__ __ __ __	
Received transplant of tissue/organs or artificial insemination	☐ Yes ☐ No ☐ Unknown
Worked in a healthcare or clinical laboratory setting	☐ Yes ☐ No ☐ Unknown
If occupational exposure is being investigated or considered as primary mode of exposure, specify occupation and setting:	
Other documented risk (please include detail in Comments)	☐ Yes ☐ No ☐ Unknown

Clinical: Acute HIV Infection and Opportunistic Illnesses (record all dates as mm/dd/yyyy)

Suspect acute HIV infection? *If YES, complete the two items below; enter documented negative HIV test data in Laboratory Data section, and enter patient or provider report of previous negative HIV test in HIV Testing History section.*	☐ Yes ☐ No ☐ Unknown
Clinical signs/symptoms consistent with acute retroviral syndrome (e.g., fever, malaise/fatigue, myalgia, pharyngitis, rash, lymphadenopathy)? Date of sign/symptom onset __ __/__ __/__ __ __ __	☐ Yes ☐ No ☐ Unknown
Other evidence suggestive of acute HIV infection? *If YES, please describe:* Date of evidence __ __/__ __/__ __ __ __	☐ Yes ☐ No ☐ Unknown

Opportunistic Illnesses

Diagnosis	Dx Date	Diagnosis	Dx Date	Diagnosis	Dx Date
Candidiasis, bronchi, trachea, or lungs		Herpes simplex: chronic ulcers (>1 mo. duration), bronchitis, pneumonitis, or esophagitis		M. tuberculosis, pulmonary[1]	
Candidiasis, esophageal		Histoplasmosis, disseminated or extrapulmonary		M. tuberculosis, disseminated or extrapulmonary[1]	
Carcinoma, invasive cervical		Isosporiasis, chronic intestinal (>1 mo. duration)		Mycobacterium, of other/unidentified species, disseminated or extrapulmonary	
Coccidioidomycosis, disseminated or extrapulmonary		Kaposi's sarcoma		Pneumocystis pneumonia	
Cryptococcosis, extrapulmonary		Lymphoma, Burkitt's (or equivalent)		Pneumonia, recurrent, in 12 mo. period	
Cryptosporidiosis, chronic intestinal (>1 mo. duration)		Lymphoma, immunoblastic (or equivalent)		Progressive multifocal leukoencephalopathy	
Cytomegalovirus disease (other than in liver, spleen, or nodes)		Lymphoma, primary in brain		Salmonella septicemia, recurrent	
Cytomegalovirus retinitis (with loss of vision)		Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary		Toxoplasmosis of brain, onset at >1 mo. of age	
HIV encephalopathy				Wasting syndrome due to HIV	

[1]If a diagnosis date is entered for either tuberculosis diagnosis above, provide RVCT Case Number:

Laboratory Data (record additional tests and tests not specified below in Comments) (record all dates as mm/dd/yyyy)

HIV Immunoassays (Nondifferentiating)

TEST 1 ☐ HIV-1 IA ☐ HIV-1/2 IA ☐ HIV-1/2 Ag/Ab ☐ HIV-1 WB ☐ HIV-1 IFA ☐ HIV-2 IA ☐ HIV-2 WB
Test brand name/Manufacturer_____ **Lab name** _____
Facility name_____ **Provider name** _____
Result ☐ Positive ☐ Negative ☐ Indeterminate **Collection Date** __ __ /__ __ /__ __ __ __ ☐ **Point-of-care rapid test**

TEST 2 ☐ HIV-1 IA ☐ HIV-1/2 IA ☐ HIV-1/2 Ag/Ab ☐ HIV-1 WB ☐ HIV-1 IFA ☐ HIV-2 IA ☐ HIV-2 WB
Test brand name/Manufacturer_____ **Lab name** _____
Facility name_____ **Provider name** _____
Result ☐ Positive ☐ Negative ☐ Indeterminate **Collection Date** __ __ /__ __ /__ __ __ __ ☐ **Point-of-care rapid test**

HIV Immunoassays (Differentiating)

☐ **HIV-1/2 type-differentiating immunoassay**
(differentiates between HIV-1 Ab and HIV-2 Ab)
Role of test in diagnostic algorithm
☐ Screening/initial test ☐ Confirmatory/supplemental test
Test brand name/Manufacturer_____ **Lab name** _____
Facility name_____ **Provider name** _____
Result[1] ***Overall interpretation***: ☐ HIV-1 positive ☐ HIV-2 positive ☐ HIV positive, untypable ☐ HIV-2 positive with HIV-1 cross-reactivity
☐ HIV-1 indeterminate ☐ HIV-2 indeterminate ☐ HIV indeterminate ☐ HIV negative
Analyte results: HIV-1 Ab: ☐ Positive ☐ Negative ☐ Indeterminate **Collection Date** __ __ /__ __ /__ __ __ __ ☐ **Point-of-care rapid test**
HIV-2 Ab: ☐ Positive ☐ Negative ☐ Indeterminate [1]Always complete the overall interpretation. Complete the analyte results when available.

☐ **HIV-1/2 Ag/Ab differentiating immunoassay** (differentiates between HIV Ag and HIV Ab)
Test brand name/Manufacturer_____ **Lab name** _____
Facility name_____ **Provider name** _____
Result ☐ Ag positive ☐ Ab positive ☐ Both (Ag and Ab positive) ☐ Negative ☐ Invalid
Collection Date __ __ /__ __ /__ __ __ __ ☐ **Point-of-care rapid test**

☐ **HIV-1/2 Ag/Ab and type-differentiating immunoassay** (differentiates among HIV-1 Ag, HIV-1 Ab, and HIV-2 Ab)
Test brand name/Manufacturer_____ **Lab name** _____
Facility name_____ **Provider name** _____
Result[2] ***Overall interpretation***: ☐ Reactive ☐ Nonreactive ☐ **Index value** _____
Analyte results: HIV-1 Ag: ☐ Reactive ☐ Nonreactive ☐ Not reportable due to high Ab level **Index value** _____
HIV-1 Ab: ☐ Reactive ☐ Nonreactive ☐ Reactive undifferentiated **Index value** _____
HIV-2 Ab: ☐ Reactive ☐ Nonreactive ☐ Reactive undifferentiated **Index value** _____
Collection Date __ __ /__ __ /__ __ __ __ ☐ **Point-of-care rapid test** [2]Complete the overall interpretation and the analyte results.

HIV Detection Tests (Qualitative)

TEST ☐ HIV-1 RNA/DNA NAAT (Qualitative) ☐ HIV-1 culture ☐ HIV-2 RNA/DNA NAAT (Qualitative) ☐ HIV-2 culture
Test brand name/Manufacturer_____ **Lab name** _____
Facility name_____ **Provider name** _____
Result ☐ Positive ☐ Negative ☐ Indeterminate **Collection Date** __ __ /__ __ /__ __ __ __

HIV Detection Tests (Quantitative viral load) Note: Include earliest test at or after diagnosis.

TEST 1 ☐ HIV-1 RNA/DNA NAAT (Quantitative viral load) ☐ HIV-2 RNA/DNA NAAT (Quantitative viral load)
Test brand name/Manufacturer_____ **Lab name** _____
Facility name_____ **Provider name** _____
Result ☐ Detectable ☐ Undetectable **Copies/mL** _____ **Log** _____ **Collection Date** __ __ /__ __ /__ __ __ __

TEST 2 ☐ HIV-1 RNA/DNA NAAT (Quantitative viral load) ☐ HIV-2 RNA/DNA NAAT (Quantitative viral load)
Test brand name/Manufacturer_____ **Lab name** _____
Facility name_____ **Provider name** _____
Result ☐ Detectable ☐ Undetectable **Copies/mL** _____ **Log** _____ **Collection Date** __ __ /__ __ /__ __ __ __

Drug Resistance Tests (Genotypic)

TEST ☐ HIV-1 Genotype (Unspecified) **Test brand name/Manufacturer** _____
Lab name_____ **Facility name** _____
Provider name _____ **Collection Date** __ __ /__ __ /__ __ __ __

Immunologic Tests (CD4 count and percentage)

CD4 at or closest to diagnosis: CD4 count _____ cells/µL **CD4 percentage** _____ % **Collection Date** __ __ /__ __ /__ __ __ __
Test brand name/Manufacturer_____ **Lab name** _____
Facility name_____ **Provider name** _____

First CD4 result <200 cells/µL or <14%: CD4 count _____ cells/µL **CD4 percentage** _____ % **Collection Date** __ __ /__ __ /__ __ __ __
Test brand name/Manufacturer_____ **Lab name** _____
Facility name_____ **Provider name** _____

Other CD4 result: CD4 count _____ cells/µL **CD4 percentage** _____ % **Collection Date** __ __ /__ __ /__ __ __ __
Test brand name/Manufacturer_____ **Lab name** _____
Facility name_____ **Provider name** _____

Documentation of Tests

Did documented laboratory test results meet approved HIV diagnostic algorithm criteria? ☐ Yes ☐ No ☐ Unknown
If YES, provide specimen collection date of earliest positive test for this algorithm __ __ /__ __ /__ __ __ __
Complete the above only if none of the following was positive: HIV-1 Western blot, IFA, culture, viral load, or qualitative NAAT [RNA or DNA]

If HIV laboratory tests were not documented, is HIV diagnosis documented by a physician? ☐ Yes ☐ No ☐ Unknown
If YES, provide date of diagnosis __ __ /__ __ /__ __ __ __

Date of last documented negative HIV test (before HIV diagnosis date) __ __ /__ __ /__ __ __ __
Specify type of test:

Treatment/Services Referrals (record all dates as mm/dd/yyyy)

Has this patient been informed of his/her HIV infection? ☐ Yes ☐ No ☐ Unknown	**This patient's partners will be notified about their HIV exposure and counseled by** ☐ 1-Health dept ☐ 2-Physician/Provider ☐ 3-Patient ☐ 9-Unknown

Evidence of receipt of HIV medical care other than laboratory test result (select one; record additional evidence in Comments)
☐ 1-Yes, documented ☐ 2-Yes, client self-report, only Date of medical visit or prescription __ __ /__ __ /__ __ __ __

For Female Patient

This patient is receiving or has been referred for gynecological or obstetrical services ☐ Yes ☐ No ☐ Unknown	**Is this patient currently pregnant?** ☐ Yes ☐ No ☐ Unknown	**Has this patient delivered live-born infants?** ☐ Yes ☐ No ☐ Unknown

For Children of Patient (record most recent birth in these boxes; record additional or multiple births in Comments)

***Child's Name**	**Child's Date of Birth** __ __ /__ __ /__ __ __ __
Child's Last Name Soundex	**Child's State Number**
Facility Name of Birth (if child was born at home, enter "home birth")	***Phone** ( )

Facility Type *Inpatient:* ☐ Hospital ☐ Other, specify _____ *Outpatient:* ☐ Other, specify _____ *Other Facility:* ☐ Emergency room ☐ Corrections ☐ Unknown ☐ Other, specify _____

***Street Address**		***ZIP Code**
City	**County**	**State/Country**

Antiretroviral Use History (record all dates as mm/dd/yyyy)

Main source of antiretroviral (ARV) use information (select one) ☐ Patient interview ☐ Medical record review ☐ Provider report ☐ NHM&E ☐ Other	**Date patient reported information** __ __ /__ __ /__ __ __ __

Ever taken any ARVs? ☐ Yes ☐ No ☐ Unknown

If yes, reason for ARV use (select all that apply)

☐ HIV Tx	ARV medications _____	Date began __ __ /__ __ /__ __ __ __	Date of last use __ __ /__ __ /__ __ __ __
☐ PrEP	ARV medications _____	Date began __ __ /__ __ /__ __ __ __	Date of last use __ __ /__ __ /__ __ __ __
☐ PEP	ARV medications _____	Date began __ __ /__ __ /__ __ __ __	Date of last use __ __ /__ __ /__ __ __ __
☐ PMTCT	ARV medications _____	Date began __ __ /__ __ /__ __ __ __	Date of last use __ __ /__ __ /__ __ __ __
☐ HBV Tx	ARV medications _____	Date began __ __ /__ __ /__ __ __ __	Date of last use __ __ /__ __ /__ __ __ __
☐ Other (specify reason) _____			
	ARV medications _____	Date began __ __ /__ __ /__ __ __ __	Date of last use __ __ /__ __ /__ __ __ __

HIV Testing History (record all dates as mm/dd/yyyy)

Main source of testing history information (select one) ☐ Patient interview ☐ Medical record review ☐ Provider report ☐ NHM&E ☐ Other	**Date patient reported information** __ __ /__ __ /__ __ __ __

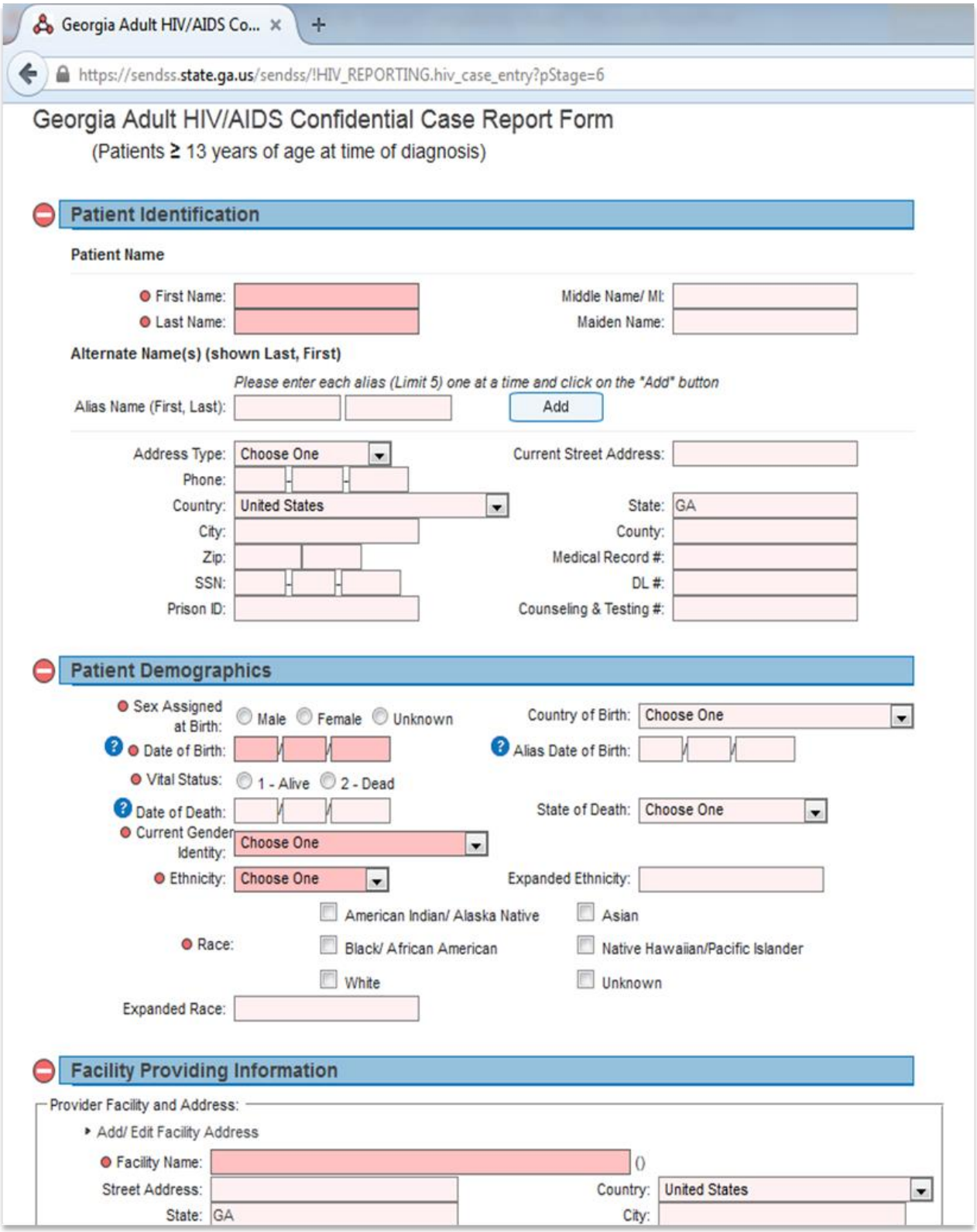
Ever had previous positive HIV test? ☐ Yes ☐ No ☐ Unknown **Date of first positive HIV test** __ __ /__ __ /__ __ __ __

Ever had a negative HIV test? ☐ Yes ☐ No ☐ Unknown **Date of last negative HIV test** *(if date is from a lab test with test type, enter in Lab Data section)* __ __ /__ __ /__ __ __ __

Number of negative HIV tests within the 24 months before the first positive test __ __ ☐ Unknown

Comments

SENDSS Portal HIV/AIDS Confidential Case Report Screenshot



Appendix G: Georgia ADAP Formulary

BRAND NAME	GENERIC NAME
NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTI's)	
Combivir	Lamivudine/Zidovudine
Descovy	Emtricitabine/Tenofovir alafenamide (TAF)
Emtriva	Emtricitabine (FTC)
Epivir	Lamivudine (3TC)
Epzicom	Abacavir/Lamivudine
Retrovir	Zidovudine (AZT)
Trizivir	Abacavir/Lamivudine/Zidovudine
Truvada	Tenofovir/Emtricitabine
Viread	Tenofovir (TDF)
Ziagen	Abacavir (ABC)
NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NNRTI's)	
Intelence	Etravirine (TMC)
Edurant	Rilpivirine (RPV)
Pifeltro	Doravirine (DOR)
Sustiva	Efavirenz (EFV)
Viramune, Viramune XR	Nevirapine (NVP)
PROTEASE & CYP3A INHIBITORS	
Aptivus	Tipranivir (TPV)
Evotaz	Atazanavir/Cobicistat
Invirase	Saquinavir (SQV)
Kaletra	Lopinavir/Ritonavir
Lexiva	Fosamprenavir (FPV)
Norvir	Ritonavir
Prezista	Darunavir (DRV)
Prezcobix	Darunavir/Cobicistat
Reyataz	Atazanavir (ATV)
Viracept	Nelfinavir (NFV)
FUSION INHIBITOR	
Fuzeon**	Enfuvirtide (ENV)
ATTACHMENT INHIBITOR	
Rukobia+,**	Fostemsavir
INTEGRASE INHIBITOR(INSTI)	
Isentress, Isentress HD	Raltegravir (RAL)
Tivicay	Dolutegravir (DTG)
CCR5 ENTRY INHIBITOR	
Selzentry***	Maraviroc (MVC)
SINGLE TABLET REGIMENS (STRs)	
Atripla	Efavirenz/ Emtricitabine/ Tenofovir
Biktarvy	Bictegravir/Emtricitabine/TAF
Complera	Emtricitabine/Rilpivirine/Tenofovir
Delstrigo	Doravirine/Lamivudine/Tenofovir
Dovato	Dolutegravir/Lamivudine
Genvoya	Elvitegravir/Cobicistat/Emtricitabine/TAF
Juluca	Dolutegravir/Rilpivirine
Odefsey	Emtricitabine/Rilpivirine/TAF
Stribild	Elvitegravir/Cobicistat/Emtricitabine/Tenofovir
Triumeq	Dolutegravir/Abacavir/Lamivudine

BRAND NAME	GENERIC NAME
ANTIVIRALS	
Famvir*	Famciclovir
Valcyte*	Valganciclovir
Valtrex*	Valacyclovir
Zovirax	Acyclovir
TUBERCULOSIS & MAC PROPHYLAXIS	
Biaxin	Clarithromycin
Isoniazid	INH
Myambutol	Ethambutol
Mycobutin	Rifabutin
Pyrazinamide	PZA
Rifadin	Rifampin
Zithromax	Azithromycin
ANTIFUNGALS	
Mycelex	Clotrimazole
Diflucan	Fluconazole
Sporanox	Itraconazole
Nizoral	Ketoconazole
Mycostatin/Nilstat	Nystatin
PCP PROPHYLAXIS/TREATMENT	
Cleocin	Clindamycin
	Dapsone
Mepron	Atovaquone
	Primaquine
	Trimethoprim
Bactrim/Septra	TMP/SMX SS & DS
TOXOPLASMOSIS	
Leucovorin	Folinic Acid
Daraprim++	Pyrimethamine
	Sulfadiazine
ANTI-CONVULSANT/ NEUROPATHIES	
Neurontin	Gabapentin
ANTI-INFLAMMATORY/ STEROID	
	Prednisone
ANTI-EMETIC/ ANTIDIARRHEAL	
Compazine	Prochlorperazine
	Loperamide
HEMATOLOGIC AGENTS	
Epogen, Procrit	Epoetin alpha

**Medications temporarily added to the formulary due to Acyclovir backorder and shortage.*
***Prior Approval Application is required.*
****Trofile® test is required indicating sensitivity to the drug.*
*+,** Rukobia has been approved for addition to the ADAP formulary, but due to funding, WILL NOT be available for dispensing before July 2021*
++ Pyrimethamine is not available for replenishment from Georgia ADAP. Please utilize https://daraprimdirect.com/ for medication assistance for ADAP uninsured clients.

NOTE: Georgia ADAP Hepatitis C Program is currently on HOLD until future funding is available. Please utilize Patient Assistance Programs (PAP's) for Hepatitis C medications.

HEPATITIS C PROGRAM MEDICATIONS	
BRAND NAME	GENERIC NAME
Epclusa	Sofosbuvir/Velpatasvir
Harvoni	Ledipasvir/Sofosbuvir
Mavyret	Glecaprevir/Pibrentasvir
Sovaldi	Sofosbuvir
Zepatier	Elbasvir/Grazoprevir
	Ribavirin

Prior Approval Application is required prior to dispensing Hepatitis C Medications.

Appendix H: Georgia ADAP Application for Prior Approval Medications

Georgia ADAP Application for Prior Approval Medications

DATE OF REQUEST:	

CLIENT INFORMATION:		
Client Name (Last, First, M):		
District/Clinic where the client is seen:		
Client/Caregiver:		
1) Patient is willing to take (or caregiver to administer) medications as directed.	☐ Yes	☐ No
2) Patient has prior evidence of adherence to therapy and medical care; and prescriber has reasonable expectation that adherent behavior will continue.	☐ Yes	☐ No
3) Patient's home has sufficient storage at the proper temperature.	☐ Yes	☐ No

DRUGS REQUESTED & REQUIRED INFORMATION:

Please complete the corresponding section for the specific drugs requested and check the appropriate boxes, or supply the response/supporting documentation.

☐ **Fuzeon (Enfuviritide)**		
1) Current antiretroviral regimen:		
2) Please attach copies of the most recent viral load, CD4 count and all available resistance testing.		
3) Proposed optimized regimen:		
4) Does the client have a history of moderate to severe adverse events/intolerances/ allergies to medications?	☐ Yes	☐ No
- **If yes**, what medications?		
- Describe the reaction:		
5) Does the client have a history of enrollment in a recent study or Expanded Access Program? ***(If yes, please provide documentation.)***	☐ Yes	☐ No

If a client's regimen includes Fuzeon, the Georgia ADAP recommends *completing a "Fuzeon Nurse Connections" enrollment form to arrange for a home visit from a Fuzeon Nurse Educator to help the client to become confident in their ability to reconstitute and inject Fuzeon. The form is available at www.fuzeon.com or via phone at 877-4FUZEON (877-438-9366).*

☐ **Selzentry (Maraviroc)**	
1) Current antiretroviral regimen:	
2) Please attach copies of the most recent viral load, CD4 count, tropism assay test, and all available resistance testing.	
3) Proposed optimized regimen:	

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Georgia ADAP Application for Prior Approval Medications

4) Does the client have a history of moderate to severe adverse events/intolerances/ allergies to medications? ☐ Yes ☐ No

- **If yes**, what medications?

- Describe the reaction:

The following section is specific to GA ADAP Hepatitis C Program.
Hepatitis C Medications are unavailable until further notice.

Please select requested regimen from the options listed below. (Ribavirin will be weight based.):

- ☐ **Harvoni (Ledipasvir-sofosbuvir)** ☐ **with Ribavirin or** ☐ **without Ribavirin**
- ☐ **Epclusa (Velpatasvir-Sofosbuvir)** ☐ **with Ribavirin or** ☐ **without Ribavirin**
- ☐ **Zepatier (Elbasvir-Grazoprevir)** ☐ **with Ribavirin or** ☐ **without Ribavirin**
- ☐ **Mavyret (Glecaprevir-Pibrentasvir)**
- ☐ **Sovaldi (Sofosbuvir) plus Ribavirin**

Requested Course of Therapy: ☐ **8 weeks** *(only Mavyret)*, ☐ **12 weeks,** ☐ **16 weeks, or** ☐ **24 weeks**

1) Client is an active and stable ADAP client. (***Requirement***) ☐ Yes ☐ No

2) Client Weight: | 3) Client Age: | 4) Client Sex:

5) Current antiretroviral regimen:

6) List of current non-HIV medications:

7) Does the client have a history of moderate to severe adverse events/intolerances/ allergies to medications? ☐ Yes ☐ No

- **If yes**, what medications?

- Describe the reaction:

8) Please attach copies of the most recent lab work: HIV viral load, CD4 count, CMP, CBC, PT/INR, pregnancy test (if woman of child bearing age), Hepatitis A (HAV) total antibody, Hepatitis C (HCV) antibody, HCV viral load, resistance-associated polymorphism test (if indicated per guidelines), HCV genotype/subtype, i.e. 1a, 1b, etc. In addition, all clients initiating HCV therapy should be assessed for HBV coinfection with HBsAg, anti-HBs, and anti-HBc, as per current AALSD guidelines and FDA Safety Announcement.

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Georgia ADAP Application for Prior Approval Medications

9) Hepatitis C Stage: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ compensated cirrhosis ☐ decompensated cirrhosis

- Please check the lab performed within the last 12 months and include a copy:

☐ Liver Biopsy ☐ FIB-4 Calculation

☐ MELD or Child-Pugh Score ☐ Non-Invasive Biomarker Testing

10) Does the client have a history of Hepatitis C treatment? ☐ Yes ☐ No

- If yes, what treatment?

- Length of treatment?

- Outcome of treatment?

11) The requesting provider is asking the State Medical Advisor to make the treatment recommendation. ☐ Yes ☐ No

***NOTE*: Providers must submit results of the test of cure Hepatitis C Viral Load (12-weeks following treatment).**

Prescriber Information:

Provider Name (Last, First, M): Phone:

Email: Signature:

Request Determination:

Date Received: Date of Decision:

☐ Request approved ☐ Request Denied

Medical Advisor (Last, First, M):

Phone: Email:

Medical Advisor/ Prescriber Signature:

Comments/Additional Information or Instructions:

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Georgia ADAP Application for Prior Approval Medications

Provider/Prescriber Guidelines:
Patient must have a repeat HIV viral load and CD4 count performed 12 and 24 weeks after initiation of the regimen to assess effectiveness.
If CD4 and/or viral load have not improved, clinical improvement (or clinically stable if condition was worsening before) must be documented for continuation of the new regimen.
The prescriber must review the state guidelines and/or restrictions concerning the use of these medications to determine that the patient qualifies.
The prescriber should be an experienced HIV/AIDS provider or should consult with a specialist and must have sufficient office/clinic capability to provide patient education and monitoring.
Guidelines: http://aidsinfo.nih.gov/guidelines / https://dph.georgia.gov/nurse-protocols
Hepatitis C Guidelines: http://www.hcvguidelines.org/
Georgia Department of Public Health Hepatitis C Testing Toolkit
FDA Drug Safety Communication: FDA warns about the risk of Hepatitis B reactivating in some patients treated with direct-acting antiretrovirals for Hepatitis C: http://www.fda.gov/Drugs/DrugSafety/ucm522932.htm?source=govdelivery&utm_medium=email&utm_source=govdelivery

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Appendix I: ADAP Contract Pharmacy (ACP) Network

ADAP CONTRACT PHARMACY (ACP) NETWORK

Pharmacy Name	Address	City/State/Zip	Phone	PIC	Delivery	Hours of Operation
Arrowhead Healthmart (Reff's)	188 Upper Riverdale Rd Suite C	Jonesboro, GA 30236	770-603-5555	Ola Reffell	N/A	M-F: 10a-6p COVID-19 – 11a-5p
Barnes Drug Store	200 S. Patterson Street	Valdosta, GA 31601	229-242-4743	Jimmy England	N/A	M-F: 9a-6p
Barney's Pharmacy	2604 Peach Orchard Rd. Suite 300	Augusta, GA 30906	706-798-5645	Ashley London	Local delivery available	M-F: 9a-7p Sat: 9a- 4p
Chatham Co. Care Center Pharmacy	107 B Fahm Street	Savannah, GA 31401	912-651-2238	Pachia Dixon	N/A	M-F: 9a-5p
Cobb Co. BOH Pharmacy	1650 County Services Pkwy.	Marietta, GA 30008	770-514-2345	Selina Moon	N/A	M-F: 8a-5:00p
Covenant Health Pharmacy, Inc	1050 Cooper Road Suite B	Grayson, GA 30017	678.585.4962	Joy Tekobo	Free Local delivery available	M-F: 9:00a-7p
Dart Drugs and Surgical	1101 Memorial Dr.	Dalton, GA 30720	706-278-1900	Shawn Konwick	N/A	M-F: 9a-7p Sat: 9a-3p
East Marietta Drugs	1480 Roswell Rd.	Marietta, GA 30062	770-973-7600	Pamela Marquess	Free Delivery w/in 5 mi. Small fee >5 mi.	M-F: 9a-5p Sat: 9:30a-1:30p
Huff's Drugs (Purvis)	136 Industrial Blvd.	Ellijay, GA 30540	706-635-7931	Danny Postell	Free Local delivery available	M-F: 8:30-6p
Lacey Drug Company	4797 South Main St.	Acworth, GA 30101	770-974-3131	Ben Flanagan	Free Delivery w/in 5 mi.	M-F: 8a-7p Sat: 9a-6p
Norcross Pharmacy	2625- A Beaver Ruin Rd.	Norcross, GA 30071	770-448-2288	Gerri Hankla	N/A	M-F: 9a-6:30p Sat: 9a-1p

ADAP CONTRACT PHARMACY (ACP) NETWORK

Pharmacy Name	Address	City/State/Zip	Phone	PIC	Delivery	Hours of Operation
Piedmont Pharmacy North (The Medical Ctr)	5601 Veterans Pkwy, Suite 1800	Columbus, GA 31904	706-321-3700	Stacy Benoit	N/A	M-F: 8:30a-5p
Rainbow Drug Store	4319 New Jesup Hwy.	Brunswick, GA 31520	912-265-5040	Daniel Griffis	Free Local delivery available	M-F: 9a-7:00p Sat: 9a-3p
Scott's Pharmacy	635 Pio Nono Ave.	Macon, GA 31204	478-742-3098	Bryan Scott	Free Local delivery available	M-F: 9a-6p Sat: 9a-1p
Wayfield Pharmacy	3050 MLK Jr Dr, Unit H	Atlanta, GA 30311	404-699-9000	Dr. Adam Vuong	Free Delivery w/in 30 miles	M-F: 9a-7p
Woodstock Pharmacy	8612 Main Street	Woodstock, GA 30188	770-926-6478	Jeff Smith	Free Delivery <5mi; $5 fee > 5miles	M-F: 9a-5p Sat: 9:30a-1:30p
Wynn's Pharmacy	566 S. Eighth Street	Griffin, GA 30224	770-227-9432	Annette Duncan	Free Local delivery available	M-F: 9a-6p Sat: 9a-2p
STATEWIDE DELIVERY PHARMACIES						
AIDS Healthcare Foundation (AHF) Lithonia	5700 Hillandale Dr. Suite 100	Lithonia, GA 30017	770-808-3705	Suzanne Lipe	Free Statewide Delivery	M-Th: 9a-6p Fri: 9a-3:30pm Sat, Sun: CLOSED
Community, A Walgreens Pharmacy	1874 Piedmont Ave. NE Suite 100 A	Atlanta, GA 30324	404-733-6800	Jaime Shockley	Free Statewide Delivery	M-F: 8a-6p Sat: 9a-12p
Curant Health	200 Technology Court SE, Bldg. 200, Suite B	Smyrna, GA 30082	770-437-8040	Pankajkumar Patel	Free Statewide Delivery	M-F: 8:30a-5:30p
Express Drugs	212 Edgewood Ave.	Atlanta, GA 30303	404-688-2211	Gholam Bakhtiari	Free Delivery	M-F: 8a-6p Sat: 9a-4p

ADAP CONTRACT PHARMACY (ACP) NETWORK

Pharmacy Name	Address	City/State/Zip	Phone	PIC	Delivery	Hours of Operation
Positive Impact Health Center (PIHC)-Decatur	523 Church Street Suite B	Decatur, GA 30030	404-977-5200	Alicia Shelton	Free Statewide Delivery	M,Th,F: 8:30a-5p T,W : 8:30a- 8p Sat: 8:30a-5p
Walgreens (Store #13873)	2675 N. Decatur Rd, Suite 101	Decatur, GA 30033	404-299-5411	Chris Smith	Free Statewide Delivery	M-F: 8a-5:30p
Walgreens (Store #15913)	2200-A East Oglethorpe Blvd	Albany, GA 31705	229-432-2895	Ashley Eschmann	Free Statewide Delivery	M-F: 8a-6p
RESTRICTED PHARMACY						
Grady IDP Pharmacy	341 Ponce De Leon	Atlanta, GA 30308	404-616-9715 404-616-9783	Alton Condra	N/A	M-F: 8a-5p

ONLY GRADY CLIENTS CAN UTILIZE GRADY IDP PHARMACY

Appendix J: 2021 FPL Guidelines

Limits on Fees for Clients Receiving Services Funded Under the Ryan White HIV/AIDS Treatment Extension (CARE) Act of 2009

Individual/Family Annual Gross Income	Total Allowable Annual Charges
Equal to or below the official poverty line	No charges permitted
101%-200% of the official poverty line	5% or less of gross annual income
201%-300% of the official poverty line	7 % or less of gross annual income
Greater than 300% of the official poverty line	10% of gross annual income

2021 FEDERAL POVERTY GUIDELINES

Annual Income Ranges

FAMILY SIZE	A <100%		B 101-150%		C 151-200%		D 201-250%		E 251-300%		F 301%-350%		G 351%-400%
1	<= $12,880	to	$13,009 to $19,320	to	$19,449 to $25,760	to	$25,889 to $32,200	to	$32,329 to $38,640	to	$38,769 to $45,080	to	$45,209 to $51,520
2	<= $17,420	to	$17,594 to $26,130	to	$26,304 to $34,840	to	$35,014 to $43,550	to	$43,724 to $52,260	to	$52,434 to $60,970	to	$61,144 to $69,680
3	<= $21,960	to	$22,180 to $32,940	to	$33,160 to $43,920	to	$44,140 to $54,900	to	$55,120 to $65,880	to	$66,100 to $76,860	to	$77,080 to $87,840
4	<= $26,500	to	$26,765 to $39,750	to	$40,015 to $53,000	to	$53,265 to $66,250	to	$66,515 to $79,500	to	$79,765 to $92,750	to	$93,015 to $106,000
5	<= $31,040	to	$31,350 to $46,560	to	$46,870 to $62,080	to	$62,390 to $77,600	to	$77,910 to $93,120	to	$93,430 to $108,640	to	$108,950 to $124,160
6	<= $35,580	to	$35,936 to $53,370	to	$53,726 to $71,160	to	$71,516 to $88,950	to	$89,306 to $106,740	to	$107,096 to $124,530	to	$124,886 to $142,320
7	<= $40,120	to	$40,521 to $60,180	to	$60,581 to $80,240	to	$80,641 to $100,300	to	$100,701 to $120,360	to	$120,761 to $140,420	to	$140,821 to $160,480
8	<= $44,660	to	$45,107 to $66,990	to	$67,437 to $89,320	to	$89,767 to $111,650	to	$112,097 to $133,980	to	$134,427 to $156,310	to	$156,757 to $178,640
9	<= $49,200	to	$49,692 to $73,800	to	$74,292 to $98,400	to	$98,892 to $123,000	to	$123,492 to $147,600	to	$148,092 to $172,200	to	$172,692 to $196,800
10	<= $53,740	to	$54,277 to $80,610	to	$81,147 to $107,480	to	$108,017 to $134,350	to	$134,887 to $161,220	to	$161,757 to $188,090	to	$188,627 to $214,960
+1	$4,540		$6,810		$9,080		$11,350		$13,620		$15,890		$18,160

NOTE: For families with more than ten members, add the amount indicated beside +1 under the appropriate poverty level for EACH additional family member.

Appendix K: Ryan White Part B/ADAP Electronic Application

Instructions for Completing the Georgia ADAP/HICP Application Form

The Medicaid Screening Worksheet must be completed before completing Section I of the Application Form.

Section I. Patient Information

Last Name:	Enter the client's last name.
First Name:	Enter the client's first name.
Middle Initial:	Enter the client's middle initial.
Maiden Name:	Enter the client's maiden name, if applicable.
Address:	Enter the client's home address.
Mailing Address:	Enter the client's mailing address, if different from home address. If the mailing and home addresses are the same, enter same as above.
Marital Status:	Check the box indicating the client's current legal marital status.
Pregnancy Status:	Check the box indicating the client's current pregnancy status.
County:	Enter the client's county.
Date of Birth:	Enter the client's date of birth using the **MM/DD/YYYY** format. Example: 01/01/1965
Social Security Number:	Enter the client's 9-digit social security number, if applicable.
Gender:	Enter the client's gender.
Ethnicity:	Indicate whether the client is Hispanic, Non-Hispanic or Unknown.
Race:	Indicate the client's race. Note: If a client does not identify with any of the races indicated on the form, check "unknown."
Telephone Number #1:	Enter the primary phone number for the client, including area code.
Telephone Number #2:	Enter the emergency phone number for the client, including area code.
Client Status:	Check the box indicating if this is a new client application, a current client recertifying or a client transferring from another enrollment site.

Section II. Clinical Information

Diagnosis Status: Indicate the client's current diagnosis status by selecting one diagnosis option.

Diagnosis: Indicate the date the diagnosis was *initially* made.

CD4: Indicate the client's current CD4 and include the date of the test. Also indicate the NADIR CD4 count, if known, and include the date.

Viral Load: Indicate the client's current HIV Viral Load and include the date of the test. Also include the highest HIV viral load, if known, and include the date.

ART History: ***ART (Antiretroviral Therapy): A standard anti-HIV treatment regimen consists of a combination of three or more drugs that suppresses retroviral replication.*** Indicate whether the client is *ART experienced* and check the box(es) to identify the client's previous means of accessing ART. If the client is new to ART, or *ART naïve*, check the box(es) that support the decision to initiate ART.

Example #1: If the client's CD4 count is 600 and he/she has never been on ART but has a history of Opportunistic Infections, the prescribing clinician will check the boxes marked ☒ ART Naïve and ☒ History of Opportunistic Infections.

Example #2: If the client's CD4 count is 800 and the client was on ART while in the Department of Corrections, the prescribing clinician will check the boxes marked ☒ ART Experienced and ☒ Department of Corrections.

Note: Case Reports MUST be attached to all new ADAP or HICP applications. The "yes" box should be checked if the Case Report is attached. If the "no" box is checked or a Case Report is not attached, the applications will not be approved.

Section III. Physician Information

Physician Information: Complete the name of the physician, clinic name, address, city, state, and zip code and phone number. The prescribing clinician must sign the form. An APRN or PA may also sign application forms but must be approved by DPH.

ADAP application/recertification forms completed and signed by an APRN must include the delegating physician's name and phone number. ADAP application/recertification forms completed and signed by a PA must include the supervising physician's name and phone number.

Section IV. Financial/Income Information

Indicate the current age of the client; his/her **gross monthly income**, and the source of income.

Assets: Complete this section by entering the amount of client assets for each of the types listed in the section.

** *Cash Assets COUNTED towards ADAP eligibility are defined as any easily accessible or liquid cash such as assets in:*

- *Checking account, savings account, short term CD (3 months or less)*
- *Non retirement stock portfolios/mutual funds*
- *Equity in rental/vacation property*

Assets NOT COUNTED towards ADAP include:

- *Life insurance policies, and retirement/pension accounts*
- *Personal residence*
- *Personal transportation*

Documentation of Income: Complete the documentation of income section and attach appropriate documents – MAGI form.

Section V. Georgia Residency

Indicate whether or not the client is currently living in Georgia.
Indicate the type of documentation the client provided to document GA residency and attach copies.
Applicants who have no proof of residency in their names may submit a Statement of Support Form from persons with whom they live. That statement must be attached to a notarized Statement of Support Form signed by the applicant.

Section VI. Third Party Payer/Insurance Information

Insurance Information: Complete this section by indicating if the client has any of the listed sources of insurance coverage. Include policy numbers, insurance company names, phone numbers, and contacts as applicable. Please include all requested Medicare, Low Income Subsidy (LIS) and/or Medicaid information. Attach information and/or documentation regarding Medicare Part D plan status and coverage details. If the applicant is not insured, please indicate in the appropriate box.

Section VII. HICP Information

HICP Information: Complete this section only if the client is applying to the Health Insurance Continuation Program (HICP).

Section VIII. Applicant Agreement

Print the client's name. This section must be signed and dated by the client, indicating that he/she understands the intent of the AIDS Drug Assistance Program and authorizes his/her HIV information to be released to the Department of Public Health, HIV/AIDS Office Unit. ***Also, inform the client that applicants do not have to declare or document citizenship or immigration status to be eligible for services.***

Section IX. Case Manager Agreement

Case manager must print his/her name and contact information and sign the application.

Section X. Checklist

The checklist is to be completed by the case manager. Each of the items on the checklist is required, if applicable, in order to enroll a client into the AIDS Drug Assistance Program. Incomplete application packets **cannot** be processed and will be returned to the enrolling agency. Please attach all supporting documents to the application **prior** to submission.

Section XI. Waiting List Criterion

In the event of a Waiting List, the CD4 count will be assessed for clients considered for enrollment as funds become available.

Income, residency, labs and other supporting documents must be included with the ADAP Application and Recertification.

Application Date

Ryan White Application

Eligibility Criteria

Applicant must have the following information before proceeding with this application:

Proof of HIV Diagnosis

Proof of Income

Proof of Georgia Residency

2021 FEDERAL POVERTY GUIDELINES
Annual Income Ranges

FAMILY SIZE		A <100%		B 101-150%		C 151-200%		D 201-250%		E 251-300%		F 301%-350%		G 351%-400%
				$13,009		$19,449		$25,889		$32,329		$38,769		$45,209
1	<=	$12,880	to	$19,320	to	$25,760	to	$32,200	to	$38,640	to	$45,080	to	$51,520
				$17,594		$26,304		$35,014		$43,724		$52,434		$61,144
2	<=	$17,420	to	$26,130	to	$34,840	to	$43,550	to	$52,260	to	$60,970	to	$69,680
				$22,180		$33,160		$44,140		$55,120		$66,100		$77,080
3	<=	$21,960	to	$32,940	to	$43,920	to	$54,900	to	$65,880	to	$76,860	to	$87,840
				$26,765		$40,015		$53,265		$66,515		$79,765		$93,015
4	<=	$26,500	to	$39,750	to	$53,000	to	$66,250	to	$79,500	to	$92,750	to	$106,000
				$31,350		$46,870		$62,390		$77,910		$93,430		$108,950
5	<=	$31,040	to	$46,560	to	$62,080	to	$77,600	to	$93,120	to	$108,640	to	$124,160
				$35,936		$53,726		$71,516		$89,306		$107,096		$124,886
6	<=	$35,580	to	$53,370	to	$71,160	to	$88,950	to	$106,740	to	$124,530	to	$142,320
				$40,521		$60,581		$80,641		$100,701		$120,761		$140,821
7	<=	$40,120	to	$60,180	to	$80,240	to	$100,300	to	$120,360	to	$140,420	to	$160,480
				$45,107		$67,437		$89,767		$112,097		$134,427		$156,757
8	<=	$44,660	to	$66,990	to	$89,320	to	$111,650	to	$133,980	to	$156,310	to	$178,640
				$49,692		$74,292		$98,892		$123,492		$148,092		$172,692
9	<=	$49,200	to	$73,800	to	$98,400	to	$123,000	to	$147,600	to	$172,200	to	$196,800
				$54,277		$81,147		$108,017		$134,887		$161,757		$188,627
10	<=	$53,740	to	$80,610	to	$107,480	to	$134,350	to	$161,220	to	$188,090	to	$214,960
+1		$4,540		$6,810		$9,080		$11,350		$13,620		$15,890		$18,160

NOTE: For families with more than ten members, add the amount indicated beside +1 under the appropriate poverty level for EACH additional family member

Attention: This form is only to be used for persons newly Applying and Annual Recertifications. Please use shortened ADAP/HICP Form for six (6) month recertifications. **Only clients and case managers must sign recerts.

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I. PATIENT INFORMATION

Last Name | First Name | Middle Name | Maiden Name

Address | City | State | Zip Code | County

Mailing Address (Street, City, State, Zip Code)

Home Phone | Mobile Phone | Marital Status | Date of Birth | SSN

Gender

Sex at Birth

Ethnicity
- ○ Non-Hispanic
- ○ Hispanic

ADAP Status | HICP Status

Race
- ☐ White
- ☐ Asian
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Other Pacific Islander

Asian Subgroup | Pacific Subgroup

Hispanic Subgroup

HIV Risk Factors
- ☐ Male Who has Sex with Male(s)
- ☐ Injecting Drug Use
- ☐ Heterosexual Contact
- ☐ Undetermined/Unknown, Risk not Reported or Identified
- ☐ Receipt of Transfusion of Blood, Blood Components, or Tissue
- ☐ Perinatal Transmission
- ☐ Hemophilia/Coagulation Disorder
- ☐ Other

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II. CLINICAL INFORMATION

Diagnosis

AIDS Diagnosis Date

HIV Diagnosis Date

CD4 COUNT

Current CD4

Current CD4 Date

☐CD4 <200 ☐CD4 200-500

☐CD4 >500

☐CD4 >500 with a condition requiring therapy

HIV VIRAL LOAD

Current Viral Load Current VL Date

☐Not Detectable (ND)

☐Pending VL

Highest Viral Load Highest VL Date

Case Report Form Attached for all new clients:

Date

ANTIRETROVIRAL THERAPY (ART) HISTORY

☐ART Experienced

☐Continuation of Therapy

☐ART Naive

☐Indications for initiating ART

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III. PHYSICIAN INFORMATION

Clinic Name

Physician's Name (if name not in list, please write in)

Clinic Address | City, State, Zip Code | Telephone Number

Physician, APRN, or PAs Signature (PA and APRN must be approved by State Office)

IV. FINANCIAL/INCOME INFORMATION

Name	Relationship to Client	Age	Gross Monthly Income	Source of Income
		Total		
		Total X 12 Months=		/a year

Change/View Poverty Level

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ASSETS

TYPE	AMOUNT
Cash on Hand	
Checking Account	
Savings Account	
Stocks	
Bonds	
Severance Pay	
Other	
Total	

NOTE: Total assets cannot exceed $10,000

DOCUMENTATION OF INCOME

☐Employment.

☐Social Security Disability Income

☐Retirement Income

☐Veterans Benefits

☐Interest/Investment Income

☐No Income

☐Other Income

Documentation Attached (Please attach documentation on Application tab)

☐Paycheck Stub for last month

☐Signed Employer Statement with Dates

☐Tax Return

☐Social Security Award Letter

☐VA Award Letter

☐Bank Statements

☐Statement of Support

☐Support and Residency Verification Letter

Other:

V. GEORGIA RESIDENCY

☐Currently living in state of Georgia?

Client provided the following to document Georgia residency (please attach to Application tab):

☐Copy of Client's Utility Bill

☐Copy of Client's Lease/Mortgage Agreement

☐Client is homeless (in Georgia) Name/Location of Shelter

☐Other (must be Documents defined in policy)

Note: A Georgia's Driver's License alone, is not adequate proof of residency

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Applicants who have no proof of residency in their names can submit a statement from persons with whom they live that is attached to a Support and Residency Verification Letter signed by the applicant.

VI. THIRD PARTY PAYER/INSURANCE INFORMATION

☐Medicaid Elig. ☐Applied? Approved? _____

☐Medicaid
☐Medicaid Spenddown (QMB)

Medicaid #: _____
Medicare #: _____

☐Medicare
☐Part A
☐Part B
☐Part D

☐Applied for Low Income Subsidy (LIS) "extra help":
☐Approved for Full Low Income Subsidy (LIS):
☐Approved for Partial Low Income Subsidy (LIS):

Applying For
☐MCare Co-Pay Assistance
☐MRx Full Pay Assistance

Medicare Part D Plan Company Name: _____

Deductible _____ Co-pays _____ Premiums _____

☐Veterans Benefits

☐Client served in Armed Forces, Reserves, or National Guard

Applying For
☐HICP Co-Pay Assit. Only
☐HICP Full Pay Assit. Only

☐Has No Insurance

Insurance Company _____
Policy # _____
Phone Number of Insurance Company _____
RxCompany _____
RxBIN _____
RxPCN _____
RxGroup _____
Contact Person _____

Change/View Insurance Assessment

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VII. HEALTH INSURANCE CONTINUATION PROGRAM (HICP) INFORMATION

We will need this information to pay your premiums. You must submit a copy of your most recent premium bill or payment coupons. Also, a copy of your Health Insurance Policy benefit information regarding pharmaceutical coverage equivalent to medications on the ADAP Formulary as well as coverage for other essential medical benefits must be attached.

Insurance or COBRA Company

Plan Name

Mailing Address (for premium remittance)

City, State, Zip Code

Telephone #

☐Private Health Insurance

What type of coverage is this?

☐Cobra ☐Individual ☐Health Care Access ☐Other Coverage

If COBRA, when is the effective date?

Note: If this is a COBRA policy, you must try to get a Health Care Access policy when the policy ends.

What is your:

Monthly Premium Rate/Amount

Quarterly Premium Rate/Amount

Policy Number

Due Date of Next Premium

The most recent premium notice or coupon must be attached.

What is the name of the company that the premium checks are made out to?

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VIII. APPLICANT AGREEMENT

I fully understand that the AIDS Drug Assistance Program (ADAP) is intended for clients with HIV infection who are unable to pay for their medications and the Georgia Health Insurance Continuation Program (HICP) is intended for clients with HIV infection who are unable to pay for their health insurance premiums. I hereby certify that the information supplied in this application and accompanying attachments is complete and accurate. I fully understand that I am responsible for completing the recertification process, every 6 months, in order to continue to receive ADAP/HICP services. If I fail to comply with this policy, I fully understand that I can be removed from ADAP/HICP.

Furthermore, I hereby authorize the release of medical information, including information about my HIV status to the HIV/AIDS Office, to all other entities involved in the processing of my ADAP or HICP documentation, to entities involved in the dispensing of my HIV/AIDS medication, and to the Pharmacy Benefit Manager (PBM). In the event of a program audit, I understand that ADAP and HICP applications, recertifications, and other supporting documentation may be subject to review by State of Georgia Auditors and I therefore authorize access to my records.

I further authorize the staff memebers of the DPH, HIV/AIDS Office to disclose my confidential information to the extent neccessary to carry out the purposes listed above.

_____ _____

Print Client Name Date

_____

Client Signature

APPLICANTS DO NOT HAVE TO DECLARE OR DOCUMENT CITIZENSHIP OR IMMIGRATION STATUS TO BE ELIGIBLE FOR SERVICES.

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IX. CASE MANAGER AGREEMENT

I attest that all of the informatin contained in this application is complete and accurate to the best of my knowledge.

ADAP / CM

HICP / CM

Case Manager's Comments

Case Manager Name (if name not available, write in)

Date

Case Manager Signature

Case Manager Email

Case Manager Phone Number

Enrollment Site

Case Manager Fax Number

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X. ADAP DISTRICT OR AGENCY STAFF MUST USE THE FOLLOWING CHECKLIST TO ENSURE THAT ALL DOCUMENTATION IS ATTACHED AND THE APPLICATION IS COMPLETE. PLEASE CHECK ALL THAT APPLY.

All applications must include the following information or documentation.

☐Section I: Patient Information is Complete

☐Section II: Clinical Info is Complete

☐Copies of Lab Results

☐Section III: Physician Information is Complete

☐Section IV: Financial Information is Complete

☐Change/View Poverty Level Link Completed

☐Proof of Income is Attached

☐MAGI Attached

☐Section V: Georga Residency is Complete

☐Proof of Georgia Residency is Attached

☐Section VI:Third Party Payer/Insurance Complete

☐Change/View Insurance Assessment Link Completed

☐Other Coverage Enrollment Screening Form

☐Request to Remain on ADAP Form

If Applicable

☐Section VII: HICP Information is Complete

Page 10

If applicant applying to HICP, Health insurance policy information regarding coverage must be attached.

☐Summary of Benefits

☐Notification of Client Responsibility is attached

☐Insurance Cards

☐Premium Statements

☐Authorization to obtain and release inform

Note: Must be faxed to the insurance company prior to submitting application

☐Medicaid Eligibility Printout

☐Copy of Medicaid/Medicare Card, if applicable

☐Copy of Medicare Part D Plan Card (Premium and/or Co-Pay Assistance)

☐Copy of denial or approval letter for LIS

☐Application has been signed and dated by:

- ☐Client
- ☐Physician
- ☐CaseManager
- ☐APRN or PA

☐Case Report is Attached

☐Application is Complete with required attachments

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Appendix L: Self-Attestation Form

Application Date

Six Month GA ADAP/HICP Recertification Self-Attestation Form

Procedure: This form is to be completed and submitted to the HIV office on or before the last day of the 5th month after the initial enrollment or 12 month annual comprehensive recerticification.

***Required: Most recent Medicaid Status printout.

Last Name | FirstName | Middle Initial/Name | Telephone Number

DOB | SSN | Gender | Marital Status

***Required: Attachment of CURRENT LABS

☐ADAP Recert Self Attestation Form

Diagnosis | HIV Diagnosis Date | AIDS Diagonsis Date | ADAP Slot | HICP Slot

Current CD4 Count (Within 6 months)

Current Viral Load (Within 6 months)

☐Not Detectable (ND) Date

RESIDENCY STATUS: Has client's residency status changed since the initial application or last recertification? ☐Yes ☐No

Verification of residency is not required for 6 Month Recertification Self Attestation unless there is a change. If there is a change, please provide documentation of current address.

Street | City | State | Zip Code | County

Mailing Address (Street, City, State, Zip Code)

FINANCIAL STATUS: Has client's Financial status changed since the initial application of last recertification? ☐Yes ☐No

Change/View Poverty Level: Verification of income is not required for 6 Month Recertification Self Attestation unless there is a change. If there is a changed, please provide documentation of current income within the last 30 days.

HEALTH INSURANCE STATUS: Does client have health insurance that includes prescription ☐Yes ☐No

Has client's health insurance coverage situation or the amount of monthly premium change since the application? ☐Yes ☐No

Change/View Insurance Assessment: Does client have a third-party insurance

☐Cobra

☐Individual

Page 1

APPLICABLE ONLY TO HICP CLIENTS WITH EXCHANGE (ACA), COBRA, OR INDIVIDUAL
Required: Attach latest premium Notice, notifcation Responsibility Form, verifcation and proof prescription and insurance coverage AND a copy of the Summary of BOTH medical and prescription plans to the HICP Insurance Information Form.

If yes, complete the HICP Insurance Information form below and attach appropriate verfication.

SELF ATTESTATION

I fully understand that the Georgia AIDS Drug Assistance Program (ADAP) is intended for clients with HIV infection who are unable to pay for their medications and the Georgia Health Insurance Continuation Program (HICP) is intended for clients with HIV infection who are unable to pay for their health insurance premiums. I fully understand that I am responsible for completing the recertification process, every 6 months, in order to continue to receive ADAP or HICP services. If I fail to comply with this policy, I fully understand that I can be removed from ADAP or HICP. I hereby authorize the release of medical information, including information about my HIV status to the HIV/AIDS Office, to all other entities involved in the processing of my ADAP or HICP documentation, to entities involved in the dispensing of my HIV/AIDS medication, and to the Pharmacy Benefit Manager (PBM). In the event of a program audit, I understand that ADAP and HICP applications, recertifications and other supporting documentation may be subject to review by State of Georgia Auditors and I therefore authorize access to my records. I hereby attest that the information and accompanying attachments supplied in this application are complete and accurate and have not changed unless otherwise indicated on this form. I understand that such information is subject to verification and further understand that the above information, if misrepresented or incomplete, may be grounds for removal from ADAP or HICP.

Client Name (Print) Client Signature Date

CASE MANAGER VERIFICATION STATEMENT:
I certify that the individual whose signature appears above provided the information provided above.

	Case Manager Name	Case Manager Email	Case Manager Phone
ADAP / CM			
HICP / CM	Case Manager Name	Case Manager Email	Case Manager Phone

Case Manager Signature Date

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HEALTH INSURANCE CONTINUATION PROGRAM (HICP) INFORMATION

☐Is the applicant enrolling or recertifying HICP?

We will need this information to pay your premiums. You must submit a copy of your most recent premium bill or payment coupons. Also, a copy of your Health Insurance Policy benefit information reguarding pharmaceutical coverage equivalent to medications on the ADAP Formulary as well as coverage for other essential medical benefits must be attached.

Insurance or COBRA Company

Plan Name

Mailing Address (for premium remittance)

City, State, Zip Code

Telephone #

Vendor ID

What type of coverage is this?

☐Cobra ☐Individual ☐Other Coverage

Note: If this is a COBRA policy, you must try to get a Health Care Policy when the policy ends.

What is your:

Monthly Premium Rate/Amount

Quarterly Premium Rate/Amount

Policy Number

Due Date of Next Premium

RxCompany

RxBIN

RxPCN

RxGroup

The most recent premium notice or coupon must be attached.

What is the name of the company that the premium checks are made out to?

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Appendix M: Statement of Support

STATEMENT OF SUPPORT

STATEMENT OF SUPPORT FOR: _____
(NAME OF APPLICANT)

SECTION 1 – If someone else provides you with support please have the individual providing support fill out this form, sign and date section 2.

_____
(NAME OF PERSON PROVIDING SUPPORT IF APPLICABLE)

What is your relationship to the applicant?
☐ Self
☐ His/her parent
☐ His/her child
☐ Relative: (Spouse, Brother, Sister, Aunt, Uncle, Partner, etc.) _____
☐ Other: (Friend, Neighbor, etc.) _____

Type of support provided (check all that apply):
☐ Lodging
☐ Food
☐ Utilities
☐ Monthly Income_____ at or below 400% **included but not limited unearned income**
☐ Other: _____

How long has the applicant lived in your household (if applicable)? _____.

Please provide the following current contact information.

Mailing address: _____
Address

_____
City, State and Zip Code

_____
Telephone Number

Please provide an explanation of your circumstances that may be helpful in determining eligibility.

_____
_____
_____

SECTION 2: By signing below, I assert that the contents of this form are complete and accurate, to the best of my knowledge.

_____ _____ _____
Support Provider Signature Applicant Signature Date

SECTION 3

APPLICANT SIGNATURE: _____ DATE: _____

NOTARY: _____

SWORN TO AND SUBSCRIBED BEFORE ME THIS _____ DAY OF _____ IN THE YEAR _____.

Appendix N: Modified Adjusted Gross Income (MAGI) Factsheet

Georgia Department of Public Health
Division of Health Protection
Infectious Disease & Immunization Section
HIV Office

MAGI Form Line Item Definitions and Documentations

MAGI Form Line Item	Definition	Documentation
Wages, Salaries, Tips, etc.	Wages, salaries, and tips received for performing services as an employee of an employer. The employer should provide a Form W-2 showing the total income and withholding.	• Form W-2* • Line 7 on Form 1040* • Paystubs • Signed employer statements • Signed/ notarized statement identifying wages
Taxable Interest	Any interest received that is credited to a person's account and can be withdrawn. This may include interest from bank accounts, investment accounts, time deposits, loans made to others, savings bonds, etc.	• Form 1099-INT* • Line 8a on Form 1040*
Tax Exempt Interest	Interest income that is not subject to federal income tax (municipal bonds). Tax-exempt interest is reported to both taxpayers and the IRS on form 1099-INT. Taxpayers, in turn, must report this tax-exempt interest on form 1040.	• Form 1099-INT box 8* • Line 8b on Form 1040*
Ordinary Dividends	A share of a company's profits passed on to the shareholders on a periodic basis (stock ownership).	• Line 9a on Form 1040*
Taxable Refunds of State/Local Income Taxes	Refunds received from state/local income taxes.	• Line 10 on Form 1040*
Alimony or other Spousal Support Received	Alimony or spousal support received.	• Line 11 on Form 1040* • Documentation of alimony
Business Income/ Loss	Business income is income earned because a person owned and operated a business. Business loss is income lost because a person owned or operated a business.	• Line 31 on Schedule C or line 3 on Schedule C-EZ* • Line 12 on Form 1040*
Capital Gain/ Loss	Profit or loss from the sale of property or an investment.	• Line 7 on Schedule D* • Line 13 on Form 1040*
Other Gains/ Losses	Revenues and gains from other than primary business activities (e.g. rent, income from patents, goodwill). It also includes gains that are either unusual or infrequent, but not both (e.g. gain from sale of securities or gain from disposal of fixed assets)	• Line 14 on Form 1040*
IRA Distributions - Taxable Amount	Taxable amount from an IRA distribution. When a person stops putting money into an IRA and begins to withdraw money from it, these withdrawals are called IRA distributions.	• Line 15b on Form 1040*
Pensions & Annuities (Veteran/ Employer Based Pensions, Retirements or disability)	Benefits in the form of pension or annuity payments.	• Line 16a on Form 1040* • Documentation of pension and/or annuity

*Documentation lists yearly amount. Totals must be divided by 12 months if using the monthly MAGI form.

Georgia Department of Public Health
Division of Health Protection
Infectious Disease & Immunization Section
HIV Office

MAGI Form Line Item Definitions and Documentations

MAGI Form Line Item	Definition	Documentation
Rental Real Estate, Partnerships, S Corporations, Trusts, Etc.	Income or loss from rental real estate, royalties, partnerships, S corporations, estates, trusts, and residual interests.	• Line 26 on Schedule E* • Line 17 on Form 1040*
Farm Income or Loss	Income and expenses for self-employed farmers.	• Line 34 on Schedule F* • Line 18 on Form 1040*
Unemployment Income	An insurance benefit that is paid as a result of a taxpayer's inability to find gainful employment. Unemployment income is paid from either a federal or state-sponsored fund. The recipient must meet certain criteria in trying to find a job.	• Line 19 on Form 1040* • Letter of award
Retirement Income from Social Security	The monetary benefits received by retired workers who have paid into the Social Security system during their working years.	• Bank Statement • Letter of award indicating pay period
Disability Income from Social Security (SSDI)	Social Security Disability Insurance is funded through payroll taxes. SSDI recipients are considered "insured" because they have worked for a certain number of years and have made contributions to the Social Security trust fund in the form of FICA Social Security taxes. SSDI candidates must be younger than 65 and have earned a certain number of "work credits."	• Bank Statement • Letter of award indicating pay period
Supplemental Income from Social Security (SSI)	Supplemental Security Income is a program that is strictly need-based, according to income and assets, and is funded by general fund taxes. To meet the SSI income requirements, a person must have less than $2,000 in assets (or $3,000 for a couple) and a very limited income.	• Bank Statement • Letter of award indicating pay period
Other Income (Jury Duty Pay, Gambling, Winnings)	Miscellaneous income. “Other income” usually includes unexpected money from an event from which a person did not receive any W-2 form.	• Line 21 on Form 1040* • Documentation of gambling or winning earnings • Documentation of jury duty pay
Child Support Received, Workers Comp, Monetary Gifts	Listing of child support received, workers compensation income, and/ or monetary gifts.	• Documentation of child support received, workers compensation, and/or monetary gifts
Educator Expenses	If a person is an eligible educator, he/she can deduct up to $250 ($500 if married, filing jointly and both spouses are educators, but not more than $250 each) of any unreimbursed expenses you paid or incurred for books, supplies, computer equipment (including related software and services), other equipment, and supplementary materials that used in the classroom.	• Line 23 on Form 1040* • Documentation of expenses incurred as an eligible educator.

*Documentation lists yearly amount. Totals must be divided by 12 months if using the monthly MAGI form.

Georgia Department of Public Health
Division of Health Protection
Infectious Disease & Immunization Section
HIV Office

MAGI Form Line Item Definitions and Documentations

MAGI Form Line Item	Definition	Documentation
Business Expenses	Any expenses incurred in the ordinary course of business. Business expenses are deductible and are always netted against business income.	• Line 6 on Form 2106 or 2106-EZ* • Line 24 on Form 1040*
Health Savings Account	A savings account used in conjunction with a high-deductible health insurance policy that allows users to save money tax-free against medical expenses.	• Line 13 on Form 8889* • Line 25 on Form 1040*
Moving Expenses	When an individual and his or her family relocates for a new job or due to the location transfer of an existing job. Based on specified criteria for time and distance.	• Line 5 if yes on Form 3903* • Line 26 on Form 1040* • Documentation of moving expenses (ex. receipts, documentation of relocating because of job purposes)
Deductible Part of Self Employment Tax	The self-employment tax refers to the employer portion of Medicare and Social Security taxes that self-employed people must pay.	• Line 12 on Schedule SE* • Line 27 on Form 1040*
Self Employed SEP, SIMPLE Plans	Self-employment retirement plans.	• Line 28 on Form 1040*
Self Employed Health Insurance Deduction	The deduction is for medical, dental or long-term care insurance premiums that **self-employed people** often pay for themselves, their spouse and their dependents.	• Line 29 on Form 1040*
Penalty on Early Withdrawal of Savings	Penalty incurred when an early withdrawal of savings is made, during which a person usually incurs an early withdrawal fee.	• Line 30 on Form 1040*
Alimony Paid	Alimony is a payment to or for a spouse or former spouse under a divorce or separation instrument. It does not include voluntary payments that are not made under a divorce or separation instrument.	• Line 31a on Form 1040*
IRA Deduction	Deductions that apply when a person makes contributions to a traditional IRA.	• Line 32 on Form 1040*
Student Loan Interest Deduction	Deduction of interest related to repaying a student loan.	• Line 33 on Form 1040*
Tuition and Fees	Deduction of qualified tuition and related expenses that a person pays for themselves, his/her spouse, or a dependent, as a tuition and fees deduction.	• Line 6 on Form 8917* • Line 34 on Form 1040*
Domestic Production Activities	A deduction against income derived from domestic manufacturing activities. It is also known as the "manufacturer's deduction."	• Line 25 on Form 8903* • Line 35 on Form 1040*

*Documentation lists yearly amount. Totals must be divided by 12 months if using the monthly MAGI form.

Appendix O: MAGI/ FPL Determination Worksheet

Georgia Department of Public Health

Monthly Modified Adjusted Gross Income (MAGI) Worksheet: Auto-Calculating

Client Name: _____ **SS#** _____ **DOB** _____
Last Name **First Name** **Initial** **(MM/DD/YY)**

Family Size: (1-8) _____ **Family Size:** (17-24) _____
Family Size: (9-16) _____ **Family Size:** (25-32) _____

Income Sources Total Monthly $ Amount for all Legal Household Members			
Wages, Salaries, Tips, etc. (Form W-2)		Pensions & Annuities (Veteran/ Employer Based Pensions, Retirements or disability)	$ -
Taxable Interest (Form 1099-INT)	$ -		
Tax Exempt Interest (Form 1099-INT box 8)	$ -	Rental Real Estate, Partnerships, S Corporations, Trusts, Etc. (Schedule E)	$ -
Ordinary Dividends	$ -	Farm Income or Loss (Schedule F)	$ -
Taxable Refunds of State/Local Income Taxes		Unemployment Income	$ -
Alimony or other Spousal Support Received	$ -	Retirement Income from Social Security	$ -
Business Income/ Loss (Schedule C or C-EZ)	$ -	Disability Income from Social Security	$ -
Capital Gain/ Loss (Schedule D)	$ -	***Supplemental Income from Social Security (SPECIALTY LINE A)**	$ -
Other Gains/ Losses	$ -	Other Income (Jury Duty Pay, Gambling, Winnings)	$ -
IRA Distributions - Taxable Amount	$ -	***Child Support Received, Workers Comp, Monetary Gifts (SPECIALTY LINE B)**	
TOTAL COLUMN 1	**$ -**	**TOTAL COLUMN 2**	**$ -**
TOTAL INCOME (Total Column 1 + Total Column 2)		**$**	**-**

NON MAGI (not calculated but required) Total Monthly $ Amount for all Legal Household Members			
Educator Expenses	$ -	Penalty on Early Withdrawal of Savings	$ -
Business Expenses (Form 2106 or 2106-EZ)	$ -	Alimony Paid	$ -
Health Savings Account (Form 8889)	$ -	IRA Deduction	$ -
Moving Expenses (Form 3903)	$ -	Student Loan Interest Deduction	$ -
Deductible Part of Self Employment Tax (Schedule SE)	$ -	Tuition and Fees (Form 8917)	$ -
Self Employed SEP, SIMPLE Plans	$ -	Domenstic Production Activities (Form 8903)	$ -
Self Employed Health Insurance Deduction	$ -		
TOTAL COLUMN 1	**$ -**	**TOTAL COLUMN 2**	**$ -**
TOTAL ADJUSTMENTS (Total Column 1 + Total Column 2)		**$**	**-**
SPECIALTY LINE A + SPECIALTY LINE B		**$**	**-**
NON MAGI SUBTOTAL (Total Adjustments + Specialty Line A + Specialty Line B)		**$**	**-**

MAGI (Total Income - Non MAGI Subtotal)	**$ -**

FEDERAL POVERTY LEVEL (FPL) (For family size 1-8)	**#DIV/0!**
FEDERAL POVERTY LEVEL (FPL) (For family size 9-16)	**#DIV/0!**
FEDERAL POVERTY LEVEL (FPL) (For family size 17-24)	**#DIV/0!**
FEDERAL POVERTY LEVEL (FPL) (For family size 25-32)	**#DIV/0!**

Appendix P: Other Coverage Screening Form

Georgia Department of Public Health
Ryan White Part B Program

Other Coverage Screening Form

Client Name	Client ID#
Employee Name	

Enrollment Screening

Y	N	N/A		
☐	☐	☐	Client was informed about other health insurance options (inclusive of Medicaid, Medicare, private insurance, etc.).	Date of Encounter: _____
☐	☐	☐	Client was referred to a Health Insurance Enrollment Assistance location in their area.	Date of Encounter: _____
☐	☐	☐	Is the client eligible for insurance through the Health Insurance Marketplace?	Date of Encounter: _____
☐	☐	☐	Is the client eligible for Medicaid?	Date of Encounter: _____
☐	☐	☐	Is the client eligible for Medicare A, B and/or D? **If yes,** please specify in the notes section.	Date of Encounter: _____
☐	☐	☐	Client will be enrolled or re-certified into Ryan White Part B/ ADAP **If yes**, and the client is eligible for a health insurance plan, please explain why in the Notes section.	Date of Encounter: _____

Notes:

Client Signature	Date
Employee Signature	Date

Edited 3/5/2019

Appendix Q: Georgia's ADAP & Medicare Part D FAQs

Georgia's AIDS Drug Assistance Program and Medicare Part D

Frequently Asked Questions
For HIV-positive Medicare Beneficiaries and Their Service Providers.

Medicare Part D affects persons on Social Security Disability Insurance (SSDI) or Social Security Administration (SSA) retirement. It does not apply to people that only get Social Security Income (SSI).

1. **What is the AIDS Drug Assistance Program (ADAP)?**
   ADAP provides HIV medications to persons who lack prescription coverage or other means to get their HIV medications. The Ryan White HIV/AIDS Treatment Modernization Extension Act of 2009 and the State of Georgia fund ADAP. The Health Resources and Services Administration set ADAP policies for all states. Georgia's ADAP is managed by the Department of Public Health. There are 26 sites where people can enroll.

2. **What is Medicare Part D?**
   Medicare Part D is a drug program with many plans sold by companies. The plans differ in things like price and covered drugs, so people should choose a plan to meet their needs. People may have to pay some drug costs. Learn more at www.medicare.gov or www.medicarerights.org, or call 800-633-4227.

3. **What is "Extra Help?"**
   Some people can get Low Income Subsidies (LIS) *Extra Help,* which greatly lowers out-of-pocket costs. Persons on both Medicaid and Medicare automatically get *Extra Help.* Persons not enrolled may apply at Social Security offices or www.ssa.gov.

4. **What is the "donut hole" (or "gap in coverage")?**
   In most plans, persons pay the first $445 of drug costs and then 25% up to $4,130. But they must pay 100% of the coverage gap between $4,130 and $6,550. This coverage gap is called the "donut hole." After paying $6,550, 95% of other drug costs for the year are covered.

5. **What does this mean for people with HIV?**
   HIV drugs are costly, so people with HIV may reach the "donut hole" quickly. But many can't even pay the first $445. ADAP may help them with some costs.

6. **How can people with HIV get drugs if they can't afford Medicare Part D?**
   People with incomes up to $19,320 for an individual or $26,130 for a married couple should apply for LIS *Extra Help*. If they get full *Extra Help* they will not have a "donut hole." They may pay $3.70 to $9.20 for each drug and may not have to pay some costs.

7. **Can ADAP assist people eligible for Medicare Part D?**
   Yes. Persons who cannot pay out-of-pocket costs should talk to their case managers at their ADAP enrollment site. Georgia ADAP may help with costs not covered by Medicare Part D.

8. **What rules apply for persons with incomes under 135% of Federal Poverty?**
   Persons with HIV on Medicare with incomes below 135% of Federal Poverty don't qualify for ADAP if they have financial help or get full LIS *Extra Help*. They should apply for LIS or Extra Help right away.

9. **What is the reason for this rule?**
   Persons that can get medications in other ways are not eligible for ADAP. ADAP is for people that can't get their medications any other way. People who get full LIS *Extra Help* have no "donut hole" or other costs.

10. **What rules apply for those with incomes over 135% of Federal Poverty?**
    Clients on Medicare or with incomes over 135% of Federal Poverty can stay on the ADAP and receive assistance with Co-Pays if they are in a Medicare Part D plan and do not get full LIS *Extra Help*.

11. **What is the reason for this rule?**
    Clients with incomes over 135% of Federal Poverty may not be able to pay Medicare Part D costs. They might be able to stay on the ADAP and receive assistance with Co-Pays.

12. **When will over 135% people have to show they are in Part D?**
    To stay on the ADAP, low-income clients on Medicare must show they are in a Medicare Part D plan at their next recertification.

13. **Tips for Very Low-Income clients (below 135% of Federal Poverty):**
    - Apply for LIS *Extra Help*.
    - Review plan options, such as pharmacies and covered medications (antiretrovirals must be covered but other mediations may not be). Learn about plans and apply online at www.medicare.gov.
    - **If you can get partial LIS or *Extra Help*, you may have co-pays to get drugs through Medicare Part D.**
    - **Clients should ask their doctors right away to write their prescriptions for 90 or 100 days to lower costs**. This is because there is a co-payment each time you get a drug. Getting a 90-day supply save money.

14. **Tips for Low-Income clients (incomes over 135% of Federal Poverty):**
    - If your income is below 150% of Federal Poverty, apply for *Extra Help*. Persons with incomes between 135% and 150% of Federal Poverty may be able to get Partial Extra Help. Sign up at Public Aid or Social Security office or at www.ssa.gov.
    - Look at the Georgia plans and sign up at www.medicare.gov. Look at plan costs (such as monthly premiums and co-pays), drug stores used and covered drugs (antiretroviral drugs must be covered but others may not be).
    - Observe ADAP rules.
    - Show proof you are in a Medicare Part D plan at you next recertification.
    - If you need help with Medicare Part D, contact your ADAP enrollment site.
    - You must pay the monthly premiums. If you don't pay them, you may not be able to be on ADAP and your Medicare Part D cost may go up.

15. What should people who are on both Medicaid and Medicare know about Medicare Part D coverage?

People on both Medicaid and Medicare (dually eligible) must use Medicare Part D for drugs. They can still use Medicaid for other medical care, such as doctor's visits.

Letters about this change were sent to dually eligible persons. They can check their status at www.medicare.gov or talk to a counselor for help.

To avoid a break in coverage, dually eligible persons are placed in Medicare Part D plans and should receive letters about the plans they have been assigned. Dually eligible persons should check www.medicare.gov to see if the plan meets their needs. Medicare Part D plans must include anti-retroviral drugs, so persons with HIV should make sure their other medications are on the plan. Most medications cost $3.70 to $9.20. But some medication may not be in the plan and may be full price. It may help to change plans.

16. What is GeorgiaCares?

GeorgiaCares (www.mygeorgiacares.org/) is the State Health Insurance Assistance Program which has staff who can talk about the Medicare Prescription Drug Program and help individuals to sign up for Medicare Part D.

Resources:

Websites

- www.medicare.gov
  Information about Medicare Part D
- www.cms.gov/Outreach-and-Education/Outreach/HIVAIDSRes/index.html?redirect=/HIVAIDSRes/
  Information Partners Can Use on: People with Medicare and HIV/AIDS
- https://www.medicare.gov/medicare-and-you
  Medicare and You 2020

Phone Numbers:

- 1-800-MEDICARE (Toll Free: (800) 633-4227)
- Social Security: 800-772-1213
- GeorgiaCares SHIP: 1-866-552-4464 (Option 4)

Appendix R: Notification of Client Responsibility for Participation in HICP

NOTIFICATION OF CLIENT RESPONSIBILITY FOR PARTICIPATION IN THE HEALTH INSURANCE CONTINUATION PROGRAM (HICP) OF GEORGIA

I, _____, am applying for assistance with payment of my health insurance premiums under the Georgia Department of Public Health (DPH) Health Insurance Continuation Program (HICP). **I understand that I am responsible for my premium payments in full until DPH approves my HICP application and sends me notification. It will take a minimum of 30 days for my completed application/recertification to be processed by DPH; however, the process may take longer if completed documentation is not received and my application is returned to the enrolling agency**. Should there be a lapse in payment, I understand that I am responsible for remittance directly to the insurance company/COBRA Administrator. **I also understand that failure to pay my insurance premiums until DPH has approved my application for the HICP may result in the loss of my insurance coverage**.

I understand that the maximum allowable monthly premium amount under the guidelines of the HICP is **$1,788.00**. My current insurance premium is $_____ per month.

I understand that it is my responsibility to provide regular monthly or quarterly billing statements to DPH to process accurate premium payments. Failing to provide billing statements may lead to termination of my policy. DPH will not be responsible for inaccurate premium payments sent to the insurance company or administrator.

I understand that it is my responsibility to maintain regular contact with my insurance company/COBRA Administrator and report any changes to my case manager as soon as I am aware of them.

I understand that if I receive a refund from the insurance company or COBRA administrator due to the termination of my policy, I must return it immediately to my enrolling agency to be forwarded to DPH **to avoid future denial for eligibility or possible legal actions.**

I understand and have been informed by my case manager that **if** I am accepted into the HICP, it is my responsibility to apply for recertification every six (6) months to continue to receive HICP benefits.

I understand that by signature of this form that I am waiving any responsibility or liability of the enrolling agency and the Georgia DPH Health Insurance Continuation Program and its staff for any loss of insurance or undue financial burden that I may experience as a result of this process. I also understand that the enrolling agency is not responsible for the approval of any HICP application and that the HICP is solely governed and administered by the DPH. I understand that this form is a DPH document to verify that I have been duly informed of my responsibilities if I am accepted into the HICP. I am aware that the signature on this form in no way guarantees approval of my application or recertification for the HICP.

Client Name: _____ Client ID#: _____

_____ _____
Client Signature Date

_____ _____
Case Manager Date

Enrolling Agency: _____

Appendix S: Repayment Agreement Form

PREMIUM REFUND REPAYMENT AGREEMENT FOR PARTICIPATION IN THE HEALTH INSURANCE CONTINUATION PROGRAM OF GEORGIA

I, _____, agree to repay to the Georgia Department of Public Health ADAP/HICP program $_____, the total premium or tax credit amount refunded to me. I am agreeing to repay $_____ monthly, for continued eligibility for the Health Insurance Continuation Program (HICP) of Georgia. I understand that premium refund repayment must be submitted by money order each month to the Georgia Department of Public Health ADAP/HICP program.

I understand that failure to remit payment for 60 consecutive days will affect current and/or future ADAP/HICP eligibility.

_____ _____
Client Name Client ID#

_____ _____
Client Signature Date

_____ _____
Case Manager Date

_____
Enrolling Agency

A COPY OF THIS SIGNED FORM MUST BE GIVEN TO THE CLIENT

Appendix T: AEP Statement of Support

AEP STATEMENT OF SUPPORT

STATEMENT OF SUPPORT FOR: _____
(NAME OF APPLICANT)

SECTION 1 – If someone else provides you with support please have the individual providing support fill out this form, sign and date section 2.

_____
(NAME OF PERSON PROVIDING SUPPORT IF APPLICABLE)

What is your relationship to the applicant?
☐ Self
☐ His/her parent
☐ His/her child
☐ Relative: (Spouse, Brother, Sister, Aunt, Uncle, Partner, etc.) _____
☐ Other: (Friend, Neighbor, etc.) _____

Type of support provided (check all that apply):
☐ Lodging
☐ Food
☐ Utilities
☐ Monthly Income_____ at or below 400% **included but not limited unearned income**
☐ Other: _____

How long has the applicant lived in your household (if applicable)? _____.

Please provide the following current contact information.

Mailing address: _____
Address
_____
City, State and Zip Code
_____
Telephone Number

Please provide an explanation about your circumstances that may be helpful in determining eligibility.

_____

_____

_____

SECTION 2
By signing below, I assert that the contents of this form are complete and accurate, to the best of my knowledge.

_____ _____ _____
Support Provider Signature Applicant Signature Date

SECTION 3

APPLICANT SIGNATURE: _____ DATE: _____

NOTARY: _____

SWORN TO AND SUBSCRIBED BEFORE ME THIS _____DAY OF _____ IN THE YEAR _____.

Appendix U: AEP Self-Attestation Form

ADAP Emergency Program (AEP)
Self-Attestation Form

Procedure: This program is intended to provide 90 days of medication coverage to individuals affected by Natural Disasters. Applicants must access the ADAP Contracted Pharmacy (ACP) Network to fill their prescriptions if approved and is subject to the Georgia ADAP formulary.

*****Required: Please attach a State ID, Driver's License or Photo ID**

First Name: _____ MI: _____ Last Name: _____ Telephone Number: ( ) -

DOB: ____/____/_____ SSN: ____/____/_____ **N/A** ☐

GENDER	**RACE**	**ETHNICITY**	**MARITAL STATUS**
☐ Male ☐ Female ☐ Transgender (Male to Female) ☐ Transgender (Female to Male)	☐ White/Caucasian ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian/ Other Pacific Islander ☐ Other	☐ Hispanic ☐ Non-Hispanic	☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

ADAP STATUS IN OTHER STATE:	**PATIENT ASSISTANCE PROGRAM (Have you applied to a PAP?):**	**MEDICAID ELIGIBILITY:**
Active ☐ In-Active ☐	Yes ☐ No ☐	Pending ☐ Denied ☐ N/A ☐ Is the client receiving Medicaid in another state? Yes ☐ No ☐

CURRENT RESIDENCY: ***Must match Statement of Support Form.

Verification of residency, please provide documentation of current address:

Address _____ City: _____ State: _____ Zip: _____ County: _____

PREVIOUS STATE OF RESIDENCY:

Address _____ City: _____ State: _____ Zip: _____ County: _____

FINANCIAL STATUS:*Please provide the Statement of Support Form.**

Is the client's current income at or below 400% of the FPL? Yes ☐ No ☐

***** Required: Attachment of CURRENT LABS FROM PREVIOUS STATE:**

Current (within 6 months) Viral Load: _____ Date: ____/____/_____

Current (Within 6 months) CD4 Count: _____ Date: ____/____/_____

Original HIV Diagnosis Date: _____ Original AIDS Diagnosis Date: _____ (please provide the approximate date)

CURRENT REGIMEN:

Medication: _____ **Dosage (mg)**:_____ **Last fill date**:_____

Medication: _____ **Dosage (mg)**:_____ **Last fill date**:_____

Medication: _____ **Dosage (mg)**:_____ **Last fill date**:_____

Previous Prescribing Physician Name:_____ **Address**:_____ **Phone Number**:_____

Previous Pharmacy:_____ **Phone Number**:_____

SELF-ATTESTATION STATEMENT:

I fully understand that the Georgia AIDS Drug Assistance Program Emergency Program (AEP) is intended for applicants with HIV/AIDS, who are unable to pay for their medications. I understand that AEP is intended for an applicant affected by a Natural Disaster. I fully understand that I am responsible for applying to ADAP after 90 days for continued eligibility. I hereby authorize the release of medical information, including information about my HIV status to the Georgia State HIV/AIDS Office, to all other entities involved in the processing of my ADAP documentation, to entities involved in the dispensing of my HIV/AIDS medication, and to the Pharmacy Benefit Manager (PBM). In the event of a program audit, I understand that the AEP application and other supporting documentation may be subject to review by State of Georgia Auditors and I therefore authorize access to my records. **I hereby attest that the information and accompanying attachments supplied in this application are complete and accurate and have not changed unless otherwise indicated on this form. I understand that such information is subject to verification and further understand that the above information, if misrepresented or incomplete, may be grounds for removal from the AEP program.**

Client Name (Print) Client Signature Date

CASE MANAGER VERIFICATION STATEMENT:

I certify that the individual whose signature appears above provided the information for this application.

Case Manager Name (Print) Phone Number Date

Appendix V: Medication Override Request Form

Georgia ADAP/HICP/Hepatitis C Medication Override Request Form

Please upload this form and supporting attachments into CAREWare

Date of Request: ☐

Client Name (Last, First, MI): ☐

ADAP/HICP Slot #: ☐ Recertification Due Date: ☐

Client's Pharmacy: ☐

Type of Request: ☐ Incident Date: ☐

Travel Departure Date: ☐ Return Date: ☐ Travel Itinerary Attached? ☐ Yes ☐ No

Number of Refills Requested? ○ 30 Days ○ 60 Days

Medication Name & Milligram: ☐

Have you explored all other sources of medication access prior to this request?

☐ Yes ☐ No

Does the client have 90 consecutive days of medication utilization?

☐ Yes ☐ No

Last 3 Fill Dates: Date: ☐ Date: ☐ Date: ☐

Brief Explanation for Request (*please attach police/incident report if available*):

DPH Use Only:

Reviewed By: ☐ Date: ☐

○ Approved ○ Denied PA #: ☐

Appendix W: ADAP/HICP Discontinuation Form

GEORGIA DEPARTMENT OF PUBLIC HEALTH
Office of HIV/AIDS
Two Peachtree Street
Atlanta, Georgia 30303-3186

ADAP/HICP DISCONTINUATION FORM

Date_____

DPH District/Approved Agency: _____ District #: _____

ADAP Coordinator/Case Manager/Designee (please print): _____

Please discontinue the following ADAP/HICP client:

Client Name (Last Name, First): _____

SS# _____ DOB (MM/DD/YY) _____ ADAP Slot # or HICP ID #_____

Was client notified of the discontinuation? ☐ Yes ☐ No ☐ NA

If no, please describe attempts to notify client. _____

Reason (select all that apply):

☐ **Transferred To _____**
☐ **New Funding Source**
[ ] Medicaid [ ] Medicare Part D [ ] Private Health Insurance Including Drug Coverage [ ] Other _____
☐ Did Not Pick Up ADAP Medication for 60 Consecutive Days or More
☐ **Death, Date_____**
☐ Moved
☐ Non-Compliant
☐ Medication Intolerant
☐ Refused Medication
☐ Did not Recertify
☐ Inactive
☐ Ineligible
☐ Incarcerated
☐ The client fails to provide necessary proof of eligibility
☐ Other_____