Before applying or re-certifying for the Georgia AIDS Drug Assistance Program (ADAP) or Health Insurance Continuation Program (HICP), the following Medicaid Screening Worksheet must be completed and attached to the application.

Please answer the following questions to assist in determining if the client is eligible for Medicaid before applying for the ADAP/HICP. Answering ***Yes*** to any of the questions may indicate that the client is eligible for Medicaid assistance. **The contact number for the Georgia Department of Community Health (DCH) is 1-888-295-1769 or via the web www.compass.ga.gov.**

1. Does the client have a Social Security Number?
   - ☐ Yes Please indicate number:_____
   - ☐ No

2. What is the current (gross) annual income for client? _____

3. Is the client a female with a minor child(ren) in the home?
   - ☐ Yes
   - ☐ No

4. Is the client 65 years of age or older?
   - ☐ Yes
   - ☐ No

5. Is the client disabled?
   - ☐ Yes
   - ☐ No

6. Has client previously applied for Medicaid, and been denied?
   - ☐ Yes
   - ☐ No

   When? _____

   Is denial being appealed? ☐ Yes ☐ No (Refer to DCH to appeal)

7. Has client's physical condition gotten worse since last applied for Medicaid?
   - ☐ Yes (Refer to back to Medicaid)
   - ☐ No

8. Has the client applied for Medicaid and been approved for full benefits.
   If yes, please stop here, client is not eligible for ADAP.
   - ☐ Yes
   - ☐ No, If no and only eligible for QMB or SLMB, continue completing the application.

9. Has the client applied for a Medicare Part D plan and LIS?
   - ☐ Yes
   - ☐ No

10. Has the client been approved for Full LIS?
    - ☐ Yes If yes, not eligible for ADAP
    - ☐ No If no, continue completing the application

GEORGIA AIDS DRUG ASSISTANCE PROGRAM (ADAP) AND HEALTH INSURANCE CONTINUATION PROGRAM (HICP) APPLICATION /RECERTIFICATION FORM

I. PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL	MAIDEN

ADDRESS **CITY AND STATE** **ZIP CODE** **County**

MAILING ADDRESS **CITY AND STATE** **ZIP CODE** **County**

MARITAL STATUS
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Separated

DATE OF BIRTH
____/____/_____

SOCIAL SECURITY #
-- --
(IF APPLICABLE)

ETHNICITY
- ☐ Hispanic
- ☐ Non-Hispanic
- ☐ Unknown

PREGNANCY STATUS
- ☐ Yes
- ☐ No
- ☐ NA
- ☐ Unknown

GENDER
- ☐ Male
- ☐ Female
- ☐ Transgender
- ☐ Unknown

RACE
- ☐ White/Caucasian
- ☐ Asian
- ☐ Native Hawaiian/ Other Pacific Islander
- ☐ Black/African American
- ☐ American Indian/Alaska Native
- ☐ Other
- ☐ Unknown

TELEPHONE NUMBER(s)
#1 ( ) -
#2 ( ) -

ADAP STATUS
- ☐ **New ADAP Application Form**
- ☐ **ADAP Recertification Form**

HICP STATUS
- ☐ **New HICP Application Form**
- ☐ **HICP Recertification Form**

☐ **Transfer From Other GA ADAP Enrollment Site: _____**

II. CLINICAL INFORMATION

DIAGNOSIS
- ☐ HIV-positive, not AIDS
- ☐ HIV-positive, AIDS status unknown
- ☐ CDC-defined AIDS
- ☐ Unknown

AIDS DIAGNOSIS DATE: ___/__/__

HIV POSITIVE DIAGNOSIS DATE: ___/__/__

CD4 COUNT

CURRENT: _____ DATE: _____/_____/_____

- ☐ NADIR CD4 Count (if known) ____ DATE: ___/__/__
- ☐ CD4 <200 DATE: ___/__/__
- ☐ CD4 200-500 DATE: ___/__/__
- ☐ CD4 >500 DATE: ___/__/__
- ☐ CD4 >500 with a condition requiring therapy (i.e. pregnancy, Hepatitis B, HIVAN, etc.)

CASE REPORT FORM ATTACHED:
YES ☐ NO ☐ DATE: _____/_____/_____

HIV VIRAL LOAD

CURRENT: _____ DATE: _____/_____/_____
HIGHEST: _____ DATE: _____/_____/_____

VIRAL LOAD TEST TYPE
- ☐ PCR
- ☐ BDNA
- ☐ NASBA

Western Blot YES ☐ NO ☐
Detectable HIV Viral Load YES ☐ NO ☐

ANTIRETROVIRAL THERAPY (ART) HISTORY

☐ **ART EXPERIENCED** (Indicate Previous Payor Source of Rx)
- ☐ Other State ADAP _____
- ☐ Patient Assistance Program
- ☐ Medicaid
- ☐ Third Party Insurance
- ☐ Department of Corrections
- ☐ Previously Enrolled in Georgia ADAP
- ☐ Other _____

☐ Continuation of Therapy

☐ **ART NAÏVE**

☐ **INDICATIONS for** initiating **ART** (Check all that apply)
- ☐ History of Opportunistic Infections
- ☐ HIV-related Malignancy
- ☐ Pregnant
- ☐ HIV-Associated Nephropathy
- ☐ Hepatitis B Treatment Indicated

PHYSICIAN'S COMMENTS:
_____

III. PHYSICIAN INFORMATION

PRINT NAME	CLINIC NAME
ADDRESS CITY STATE ZIP	
PHYSICIAN, APRN or PA's SIGNATURE (APRN or PA must be approved by DPH)	
Name - Delegating Physician for APRN or Supervising Physician for PA	Telephone Number

IV. FINANCIAL/INCOME INFORMATION

FAMILY SIZE

NAME	RELATIONSHIP TO CLIENT	AGE	GROSS MONTHLY INCOME	SOURCE OF INCOME
APPLICANT	**SELF**			
		TOTAL	$	
		TOTAL X 12 MONTHS =		$ / YEAR

ASSETS

TYPE	AMOUNT
CASH ON HAND	$
CHECKING ACCOUNT	$
SAVINGS ACCOUNT	$
STOCKS	$
BONDS	$
SEVERENCE PAY	$
OTHER	$
TOTAL	**$**

NOTE: Total assets cannot exceed $10,000.

DOCUMENTATION OF INCOME

Type of Income (indicate all that are applicable):	Documentation Attached:
☐ Employment	☐ Paycheck Stub for last month ☐ Signed Employer Statement with Dates ☐ Tax Return ☐ Other (Specify):
☐ Child Support Payments	☐ Court Order/Copy of Check
☐ Social Security Disability Income (SSDI)	☐ Social Security Award Letter
☐ Supplemental Security Income (SSI)	☐ SSI Award Letter
☐ Veterans Benefits	☐ VA Award Letter
☐ Interest/Investment Income	☐ Bank Statements ☐ Other (Specify):
☐ Other	☐ Paycheck Stub for last month ☐ Signed Employer Statement with Dates ☐ Tax Return

	☐ Other (Specify):
☐ No Income Please complete the Support and Residency Verification Letter	☐ Signed Statement of Source of Living Expenses (i.e.,Family/Friends, with Witness Signature) ☐ Support and Residency Verification Letter

V. GEORGIA RESIDENCY

The client is currently living in the State of Georgia?	☐ Yes ☐ No
Client provided the following to document Georgia residency:	**Documentation Attached:**
Copy of Client's Utility Bill	☐ Yes ☐ No
Copy of Client's Lease/Mortgage Agreement	☐ Yes ☐ No
Client is homeless (in Georgia) Shelter Name/Location:	☐ Yes ☐ No
Georgia Driver's License or Georgia State ID **NOTE**: A Georgia Driver's license alone, is not adequate proof of residency	☐ Yes ☐ No

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 ☐ yes ☐ no ☐ MEDICAID SPENDDOWN (QMB) ☐ yes ☐ no	MEDICAID #: N/A ☐
☐ MEDICARE ☐ yes ☐ no ☐ PART A ☐ PART B ☐ PART D	MEDICARE HICN#: N/A ☐ Applied for Low Income Subsidy (LIS) "extra help": ☐ yes ☐ no Approved for Full Low Income Subsidy (LIS) "extra help" ☐ yes ☐ no Approved for Partial Low Income Subsidy (LIS) "extra help" ☐ yes ☐ no MEDICARE Part D Plan Company Name: _____ Deductible $_____ Co-pays $_____
☐ VETERANS BENEFITS	Did the client ever serve in the Armed Forces, Reserves, or National Guard? ☐ yes ☐ no
☐ PRIVATE HEALTH INSURANCE ☐ INDIVIDUAL ☐ GROUP ☐ COBRA INCLUDES DRUG COVERAGE ☐ yes ☐ no	INSURANCE COMPANY: POLICY #: PHONE NUMBER OF INSURANCE COMPANY: ( ) - CONTACT PERSON:
☐ ENROLLED IN THE PRE-EXISTING CONDITION INSURANCE PLAN (PCIP) ☐ yes ☐ no ☐ PCIP Authorization to Share Personal Health Information is attached* *All new ADAP applicants and persons recertifying must have a completed PCIP Authorization to Share Personal Health Information on file whether they are enrolled in PCIP or not. If an ADAP client is selected for PCIP, we must have a completed PCIP Authorization to Share Personal Health Information on file. Completing this form does not imply that an applicant is automatically enrolled in PCIP.	

VII. HEALTH INSURANCE CONTINUATION PROGRAM (HICP) INFORMATION

Is the applicant enrolling or recertifying in HICP? ☐ Yes ☐ No
(If applicant is not enrolling or recertifying in HICP, this section is not required.)

We will need this information to pay your premiums. You must submit a copy of your most recent premium bill or payment coupons.

Insurance or COBRA Company:	
Plan Name:	
Mailing Address (for premium remittance):	
City:	**State:**
Zip Code:	
Telephone Number:	

What type of coverage is this?

☐ **COBRA** ☐ **Individual** ☐ **Conversion** ☐ **Group/Long Term** ☐ **Other: _____**

If COBRA, when is the effective date?

NOTE: If this is a COBRA policy, you must try to get a conversion policy when the policy ends.

What is your:

Monthly Premium Rate/Amount: $ _____

Policy Number: _____

Due Date of the Next Premium: _____

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

_____
COBRA or Insurance Company Name

VIII. APPLICANT AGREEMENT

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 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 or HICP services. If I fail to comply with this policy, I fully understand that I can be removed from ADAP or 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, also authorize designated staff members of the Georgia Department of Public Health (DPH), HIV/AIDS Office to represent me for the following purposes:

1. Applying for coverage under the Pre-Existing Condition Insurance Plan (PCIP) if I am selected.
2. Enrolling me in the PCIP if I am offered coverage; and
3. During my ADAP enrollment, facilitating the payment of premiums for PCIP coverage by the ADAP provided that the ADAP determines that the PCIP coverage remains the most cost effective means to provide me with HIV medication for which I am seeking assistance from the ADAP.
4. Facilitating the payment of medication co-payments for HIV medication, the payment of medical co-payments for approved services that are not on the exclusion list.
5. Communicating with PCIP about the status of my PCIP enrollment and my PCIP ID#; the status of premium payments and my medical and medication co-pays and deductible.
6. Communicating with my case manager(s) and providers about my medical co-payments and my deductible.

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

Note: Case Managers are notified prior to the enrollment of selected clients in the PCIP.

_____ _____/_____/_____

Print Client Name Date

_____

Client Signature

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

IX. CASE MANAGER AGREEMENT

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

CASEMANAGER'S COMMENTS:

Date:

_____
Print Case Manager Name

_____
Case Manager Signature

_____
Case Manager ID#

(_____)_____-_____
Case Manager Phone Number

(_____)_____-_____
Case Manager Fax Number

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	☐ Medicaid Screening Worksheet is Complete
☐ Section II: Clinical Information is Complete ☐ Copies of Lab Results (CD4 and/or Viral Load) (Tests must not be more than 6 months old)	☐ Copy of Medicaid/Medicare Card, if applicable ☐ Copy of Medicare Part D Plan enrollment card (if applicable) ☐ Copy of denial or approval letter for Low Income Subsidy (LIS)
☐ Section III: Physician information is Complete	
☐ Section IV: Financial Information is Complete ☐ Proof of Income is Attached	☐ Application Has Been Signed And Dated By: ☐ Client ☐ Physician ☐ Case Manager ☐ APRN or PA
☐ Section V: Proof of Georgia Residency is Attached	
☐ Section VI: Third Party Payer/Insurance information is complete. All applicable coverage must be checked.	☐ Case Report is Attached
☐ Section VII: HICP Information is Complete, if applicant applied to HICP	☐ Notification of Client Responsibility is attached, signed and dated by client and case manager.
☐ PCIP Authorization is Attached	☐ Application is Complete with all required attachments

FOR DPH USE ONLY	
DATE RECEIVED	DISPOSITION OF APPLICATION ☐ NO PROOF OF HIV+ STATUS ☐ INCOME EXCEEDS CURRENT CRITERION ☐ NO PROOF OF GEORGIA RESIDENCY ☐ CLIENT HAS INSURANCE (WITH RX COVERAGE) ☐ CLIENT HAS OTHER PAYOR SOURCE ☐ CLIENT EXCEEDS MEDICAL ELIGIBILITY CRITERION ☐ INCOMPLETE APPLICATION* ☐ WAITING LIST PRIORITY LEVEL: _____(If applicable) ☐ APPROVED ☐ NOT APPROVED
	_____ REVIEWED BY _____ Date
	_____/_____/_____ *DATE RETURNED TO ENROLLING AGENCY

THIS APPLICATION FORM MUST NOT BE ALTERED

Instructions for Completing the Georgia ADAP/HICP Application/Recertification Form

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

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 viral load, if known, and include the date.

ART History: ***ART (Antiretroviral Therapy): An aggressive anti-HIV treatment usually including a combination of three or more drugs that suppresses or stops 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 #2: 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 #3: 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 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 3

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 from persons with whom they live. That statement must be attached to a notarized Support and Residency Verification Letter 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. Complete the PCIP section by indicating if the applicant has PCIP. Also, require the applicant to complete the PCIP Authorization to Share Personal Health Information. All new ADAP applicants and persons recertifying must have a completed PCIP Authorization to Share Personal Health Information on file at the State ADAP office whether they are enrolled in PCIP or not. Completing this form does not mean that an applicant is automatically enrolled in PCIP. In the event that future plans require the ADAP office to enroll selected individuals into PCIP, the PCIP Authorization to Share Personal Health Information form will allow ADAP staff to communicate the PCIP office. 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.

The Medicaid Screening Worksheet, income, residency, labs and other supporting documents must be included with the ADAP Application and Recertification.

When completing a web application, supporting documents are to be submitted electronically to Ramsell Corporation via the document upload process during the enrollment entry or via fax to 1-800-848-4241.