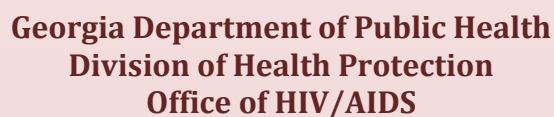




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Introduction

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, 2018.

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 \$2.3 billion in 2018.

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.
 - **The Minority AIDS Initiative** provides funding to evaluate and address the disproportionate impact of HIV/AIDS among African Americans and other minorities.

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. The ADAP started as a Health Resources and Services Administration (HRSA) demonstration project to provide zidovudine (AZT), the first drug approved by Food and Drug Administration (FDA) to treat HIV infection. Since that time, ADAPs have significantly expanded to cover other FDA approved drugs to treat HIV infection and HIV-related opportunistic infections. Georgia ADAP services are available to all eligible residents throughout all 18 health districts in the state. There are 27 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 has also expanded 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.

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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

The Georgia Hepatitis C is a state administered program that assists eligible ADAP/HICP participants living with HIV disease and Hepatitis C disease with medications covered on the Georgia ADAP formulary. The program will provide Hepatitis C 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 available for active ADAP/HICP participants and should apply 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 to care.

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. 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 persons living with HIV/AIDS 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

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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. Funded agencies should work with their community and public health partners to improve outcomes across the Continuum, 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 submitting the Ryan White Part B HIV Care Application when required.

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 yearly 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](#). Each sub-recipient 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. Programmatic/quality reports allow sub-recipients 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.

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

Quarter	Due Date
April-June	July 20
July-September	October 20
October-December	January 20
January-March	April 20

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. 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. When developing the budget, sub-recipients must be aware that 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. For those sub-recipients receiving

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the additional funds, the 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.

Sliding Fee Scale

Sub-recipients shall implement a sliding fee scale policy. If the sub-recipient accepts reimbursement for primary care and support services from any third-party payer (such as private insurance or Medicaid), 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 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

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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

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
- 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

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

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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 Dispensing 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 90 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 utilize 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, districts 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 25 th 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 25 th 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 25 th of the new FY.
FY Implementation Plan	N/A	Due April 25 th 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 (<i>refer to Figure 1 for dates</i>)
Quarterly Implementation Plan	N/A	Due quarterly (<i>refer to Figure 1 for dates</i>)

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Report	Supporting Documentation	Due Date
<i>(includes numbers and expenses for quarter of submission)</i>		
Programmatic/Quality Report	QM meeting minutes, updated QM Plan	Due quarterly (<i>refer to Figure 1 for dates</i>)
MAI Data Reports (<i>only applies to those districts funded for MAI</i>)	N/A	Due the 15 th 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

Quality Management (QM) Expectations

Funded agencies are expected to refer to the Georgia Ryan White Program Part B CQM Plan which contains goals, objectives and strategies to ensure the implementation and monitoring of quality management activities, as well as compliance with HRSA's CQM expectations at both the state and local levels. Office of HIV/AIDS Ryan White Part B Program activities are delineated in the plan, including capacity building and providing quality-related technical assistance to funded health agencies. The statewide CQM Core Team provides oversight and facilitation of the plan and is composed of multidisciplinary professionals, with representation from each funded agency, including agency staff and/or consumers.

Quality and Programmatic Compliance

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

- Ensure that the medical management of HIV infection is in accordance with the United States Department of Health and Human Services (DHHS) HIV-related guidelines.
- Ensure compliance with the Georgia Department of Public Health (DPH), Office of HIV/AIDS manual, Georgia Ryan White Part B Clinic Personnel Guidelines (current edition).
- Ensure that registered professional nurses (RN), nurse practitioners (NP), and physician assistants (PA) 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, Section 10. HIV-Infected Adult
 - Georgia Department of Public Health, Guidelines for Public Health APRN Prescriptive Authority
 - Georgia Department of Public Health Policy #PT-18001, Georgia ADAP APRN Prescriptive Authority for APRNs Not Employed by Public Health Policy and Procedure (current edition).
 - Georgia Department of Public Health Policy #PT-18002, Georgia ADAP Physician Assistant Provider Status Policy and Procedure (current edition).
- Compliance with United States Department of Health and Human Services (DHHS) HIV-related 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 the AIDSinfo website <http://aidsinfo.nih.gov/>.

- 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 Clinical QM Program according to HRSA's HIV/AIDS Bureau (HAB) expectations for Ryan White recipients. Include the following:
 - A written QM Plan, which is updated annually
 - Project-specific continuous quality improvement (CQI) plan (e.g., work plan)
 - A leader and team to oversee the Clinical QM Program
 - QM goals, objectives and strategies
 - Performance measures and mechanisms to collect data
 - Communication of results to all levels of the organization, including consumers as appropriate
- Participate in the statewide Part B Clinical QM Program.
- Monitor performance measures as determined by the Part B Clinical QM Program.
- Participate in HIV clinical and case management chart reviews conducted by state office QM staff.
- Provide QM Plans, reports (to include Quality Improvement activities), and other information related to the local QM Program as requested by the Office of HIV/AIDS Ryan White Part B District Liaison and/or QM staff. Allow the District Liaison and/or QM staff access to all QM information and documentation.
- Ensure compliance with the Georgia HIV/AIDS Case Management Standards (current edition), including the following:
 - Case managers utilize the standardized case management client intake form or an equivalent for agencies using electronic medical records (EMRs).
 - Clients receiving any medical or non-medical Part B funded service must be enrolled in Case Management.
 - All new and re-enrolling case managed clients must have an Intake, Acuity Scale, Individualized Service Plan (ISP) and case note completed within 15-30 days of intake.
 - ISPs must be completed for every new and re-certifying client at least every 6 months.
 - If an ADAP/HICP client already has a case manager, the same ISP can be utilized for the ADAP/HICP client charts.
 - The ISP and case note documentation should reflect how healthcare outcomes are being improved and/or by providing guidance and assistance in improving access to needed services for client.

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 for the Part B program. The following is a description of the overall program and fiscal monitoring policy and activities.

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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 HAB through the Ryan White HIV/AIDS Program Services Report (RSR). It is a requirement that all subrecipients 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 in English and Spanish updated/signed annually
- Security and confidentiality
- Linkages to external providers
- Grievance policies in English and Spanish 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 electronically and as hard copies. Invoices provide required information based on contract deliverables 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

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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/policies 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.

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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.

QM Coordinator: 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 which provides medication and health insurance premium and medication co-pay assistance to persons living with HIV/AIDS. Provides technical assistance and recommends policies and procedures for the development and implementation of the ADAP, HICP and other HIV related programs. The ADAP/HICP Manager 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; developing, coordinating, and participating in educational programs and ADAP education for pharmacy staff, nurses, and other disciplines; developing HIV-related policies, procedures, and protocols, 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 HIV Office, 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, policies 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 other 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

Table 2. Required Documentation Table

	Initial Eligibility Determinations and Once a Year/12-Month Recertification Determination	Recertification (once every 6 months)
Income	Documentation required	Self-attestation of no change. Documentation required if there are changes <i>(*NOTE: Clients who have marketplace plans must also report changes in income to the Marketplace)</i>
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.

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, Videx, Zerit, 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 of Florida, South Carolina, Tennessee, and Alabama 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, and may receive services and drugs free of charge through the program. 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.

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- 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 Support and Residency Verification Letter (**Appendix M**) as well as submit a Statement of Support Form from the person with whom he/she is living (**Appendix N**).
- If a client states that he/she has income at or below 99% of the FPL (e.g., \$990.00 or less monthly), a notarized Support and Residency Verification Letter 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 taken into account. 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 O**.
 - 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)

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- 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, or if the client cannot provide the statement of support, the client must make a notation on the Support and Residency Verification Letter. **Only use the updated versions of these documents. Previous versions will not be accepted with the applications. The Support and Residency Verification Letter cannot be changed or altered after it is signed and notarized.**

NOTE 3: If a spouse's income is reported as zero, a Support and Residency Verification Letter 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 P**) to determine FPL. The worksheet walks the sub-recipient through the 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 2018 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

Policies and Procedures

*must be completed electronically using Excel, saved as a PDF file and updated. **Hand written 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 may include at least two of the following:
 - Georgia state identification card (ID)/driver’s license (*not required if at least two other forms of residency documentation are provided*)
 - 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 Support and Residency Verification Letter, and the Statement of Support 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 Support and Residency Verification Letter 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, or if the client cannot provide the statement of support, the client must make a notation on the Support and Residency Verification Letter. **Previous versions of these documents or handwritten notes will not be accepted with the applications.***

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NOTE 1: A Georgia ID or driver's license, alone, is **not** adequate proof of residency and must be accompanied by one of the above for further confirmation. 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 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 of 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 Private Insurance Enrollment Screening Form (**Appendix Q**), 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.

Policies and Procedures

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 Private Insurance Enrollment Screening Form, or approved equivalent, must be uploaded along with ADAP applications and each subsequent recertification.

NOTE 2: The Private Insurance Enrollment 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. In the event that ADAP cannot assist 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 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.

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- 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 Data Rx 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

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***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 more costly 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 R**.

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 Health Insurance Marketplace plans available in their districts, 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, these 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 Health Insurance Marketplace 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 Private Insurance Enrollment Screening Form (**Appendix Q**), referrals to enrollment assistance, and notes about educational efforts in the client files. Educational efforts include letting the client know there may be other options available to them, providing them with information as to where they can get assistance with enrollment into a marketplace plan (e.g., contact information for Navigators), and informing clients about any consequences for not enrolling in a plan if they are eligible. Specifically, clients should be informed that if someone can afford but doesn't have health insurance coverage, they may have to pay a fee. Copies of informational letters/brochures utilized to educate clients should be kept on record for monitoring purposes.

Clinics can utilize a Certificate of Exemption, a printout/screenshot of non-eligibility from the health insurance marketplace portal, or proof of income if the client is below 100% FPL as documentation for non-eligibility to a marketplace plan. Useful links with information about the different types of exemptions and who qualifies can be found under **References**. Verification that

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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 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. If a client is eligible for other coverage but declines to enroll, the sub-recipient must keep a “Request to Remain on ADAP and to Decline other Coverage” form (**Appendix S**) in the client file, and a notation needs to be made on the Private Insurance Enrollment Screening Form. This form must be completed every time the client declines to enroll. The decision not to select other coverage when available could affect placement on the wait-list if one needs to be implemented.

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 T**) 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 U**) 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. ADAP Emergency Program

The ADAP Emergency Program (AEP) is intended to assist victims of a Natural Disaster. 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 V**)
- AEP Self-Attestation Form (**Appendix W**)

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 Health Department Enrollment sites or other approved agencies. In addition, HICP applications **must** include the Notification of Client Responsibility for Participation Form (**Appendix T**), 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.

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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.*

*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.*

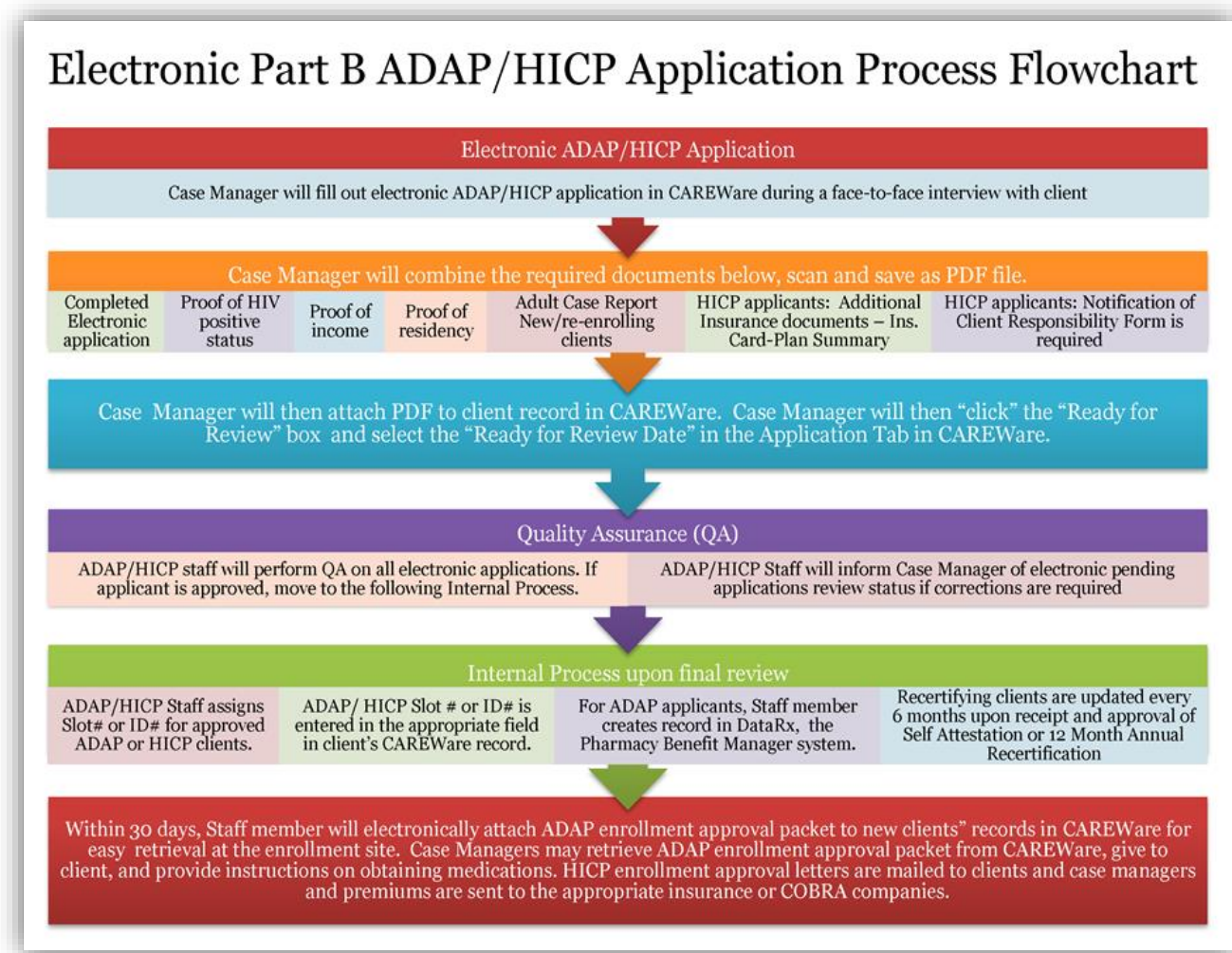
NOTE 2: *Failure to submit the Notification of Client Responsibility for Participation Form and any of the other above referenced documents will result in an incomplete HICP application status and a delay in payment processing. These documents are required for all new applications and recertifications.*

II. Incomplete Applications

Incomplete Applications **cannot** be processed.

NOTE: *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 M** 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

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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 comprised of statewide point of service pharmacies that facilitate formulary management, medication counseling and adherence, and compliance monitoring. The ACP Network allows eligible ADAP clients to utilize any participating pharmacy of their choice for ADAP prescription services.

I. ADAP Formulary

The Georgia ADAP formulary 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 order for clients to have access to these medications. In addition to the other documentation required, the Georgia ADAP Application for Prior Approval Medications 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, and approve or deny the applications. If an application is denied, the Medical Advisor will contact the prescribing provider to discuss or request additional information. All clients of denied applications have the right to appeal the decision (see Fair Hearings and Grievance Policy).

Table 2. Prior Approval Medications

GEORGIA ADAP PRIOR APPROVAL MEDICATIONS		
BRAND NAME	GENERIC NAME	COMMENT
Fuzeon	<i>Enfuvirtide</i>	<i>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.</i>
Selzentry	<i>Maraviroc</i>	<i>Trofile® test is required indicating sensitivity, i.e. CCR5 only virus identified, to the drug. The test will be the responsibility of the ADAP enrollment site until the Office of HIV/AIDS Part B Program identifies a formal viable method to fund the test.</i>

GEORGIA ADAP PRIOR APPROVAL MEDICATIONS		
BRAND NAME	GENERIC NAME	COMMENT
Videx, Videx EC	<i>Didanosine</i>	<i>Prior Approval required on all new prescriptions for Videx (Didanosine). Existing prescriptions are exempt from submission of prior approval forms.</i>
Zerit	<i>Stavudine</i>	<i>Prior Approval required on all new prescriptions for Zerit (Stavudine). Existing prescriptions are exempt from submission of prior approval forms.</i>
Daklinza	<i>Daclatasvir</i>	<i>Prior approval required on all initial fills for Hepatitis C Medication program.</i>
Harvoni	<i>Ledipasvir/Sofosbuvir</i>	<i>Prior approval required on all initial fills for Hepatitis C Medication program.</i>
Sovaldi	<i>Sofosbuvir</i>	<i>Prior approval required on all initial fills for Hepatitis C Medication program.</i>
Technivie	<i>Ombitasvir/Paritaprevir/Ritonavir</i>	<i>Prior approval required on all initial fills for Hepatitis C Medication program.</i>
Viekira PAK	<i>Ombitasvir/Paritaprevir/Ritonavir /Dasabuvir</i>	<i>Prior approval required on all initial fills for Hepatitis C Medication program.</i>
Zepatier	<i>Elbasvir/Grazoprevir</i>	<i>Prior approval required on all initial fills for Hepatitis C Medication program.</i>
Epclusa	<i>Velpatasvir-Sofosbuvir</i>	<i>Prior approval required on all initial fills for Hepatitis C Medication program.</i>
Mavyret	<i>Glecaprevir-Pibrentasvir</i>	<i>Prior approval required on all initial fills for Hepatitis C Medication program.</i>
	<i>Ribavirin</i>	<i>Prior approval required on all initial fills for Hepatitis C Medication program.</i>

III. Hepatitis C Program

- 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 X**) 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 X**) 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 Medication Prior Approval 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 Application for Prior Approval 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 X**) 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 is subject to review by the Georgia Department of Public Health 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 to the Georgia ADAP/HICP program.
- 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.**
- Replacement medication requests must meet the following eligibility criteria before consideration and approval:
 - Current ADAP/HICP program participation
 - 90 consecutive days of medication utilization

- Complete Medication Replacement 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 lack of sufficient funding. As a result, the State ADAP Office will implement a waiting list should ADAP experience the inability to serve all eligible applicants.

During the implementation of a waiting list, the State ADAP 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 ADAP Office when a patient discontinues or terminates ADAP or HICP services. The ADAP/HICP Discontinuation Form (**Appendix Y**) must be completed and sent to the State ADAP Office.

I. Reasons for Discontinuation

Discontinuation or termination of services from ADAP may occur for a number of 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 apply for re-enrollment (if there is not a waiting list) at a later date if they are able to supply appropriate documentation.*

Discontinuation or termination of services from HICP may occur for a number of 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 Y**).
- 2) Document the reason for disenrollment on the form, noting that the client was notified of the action or that there were attempts 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 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, attended at all times, 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 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 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 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.

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, Section 10. Standard Nurse Protocols for HIV/AIDS](#)
- Georgia Ryan White Program [Part B Quality Management](#) Plan April 2018 - March 2019
- Health Insurance Marketplace: [Exemptions from the Requirement to have Health Insurance](#)
- 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 Ryan White Part B National Monitoring Standards:
 - [Universal](#)
 - [Program](#)
 - [Fiscal](#)
- Ryan White HIV/AIDS Program [Legislation](#)
- National HIV/AIDS Strategy [\(Updated to 2020\)](#)



APPENDICES

Policies and Procedures

Appendix A: Part B Primary Care Clinics

District 1-1 (Rome)	Janet Eberhart	706-295-6701
Northwest GA Specialty Care Clinic	Monday - Wednesday	8:00 am - 5:00 pm
16 East 12th Street, Suite 202	Thursday	8:00 am - 6:00 pm
Rome, GA 30161	Friday	8:00 am - 2:00 pm

<i>Satellite Clinic</i>	Janet Eberhart	706-295-6701
Catoosa County Health Department	2 nd Thursday	8:00 am - 2:00 pm
145 Catoosa Circle		
Ringgold, GA 30736		

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

District 1-2 (Dalton)	Jeff Vollman	706-281-2360
<i>The Living Bridge Center</i>	Monday - Thursday	7:30 am - 5:30 pm
1200 West Waught Street, Suite A		
Dalton, GA 30720		

<i>Satellite Clinic</i>	706-281-2360	
Cherokee Co.- Canton Health Dept.	First and third Mondays of each month	
1219 Univeter Road	9:00 am - 4:00 pm	
Canton, GA 30114		

<i>Satellite Clinic</i>	706-281-2360	
Fannin County Health Department	Six times annually, call for schedule	
95 Ouida Street	9:00 am - 4:00 pm	
Blue Ridge, GA 30513		

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

District 2 (Gainesville)	Karla Henriquez	770-535-5801
Hall County Health Department	Fax	770-535-5742
1290 Athens Street	Monday/Wed./Thurs.	8:00 am - 5:00 pm
Gainesville, GA 30507	Tuesday	8:00 am - 7:00 pm
	Friday	8:00 am - 3:00 pm

<i>Satellite Clinic</i>	Karla Henriquez	770-535-5801
Stephens County Health Dept.	2 nd and 4 th Wednesday of each month	
64 Boulevard	9:00 am - 3:00 pm	
Toccoa, GA 30577		

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

Policies and Procedures

District 3-1 (Cobb-Douglas)

Capstone Health
1650 County Services Parkway SW
Marietta, Georgia 30008-4010

Tarai Kemp Brown 770-514-2817
Receptionist 770-514-2464
Monday - Friday 8:00 am - 5:00 pm

Counties include: Cobb, and Douglas

District 3-3 (Clayton)

Specialty Unit
Clayton County Board of Health
1117 Battlecreek Road
Jonesboro, GA 30236

Hawa Kone 678-610-7199
Monday - Friday 8:30 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)

Primary care provided at:
Positive Impact Health Center
3350 Breckenridge Blvd., Suite 200
Duluth, Ga. 30096-7612

Karen Cross 678-990-6415
Monday - Friday 8:00 am - 5:00 pm
1st and 3rd 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

Tina Adamson 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

District 5-1 (Dublin)

South Central Health District
103 Mercer Drive, Suite B
Dublin, Georgia 31021

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

District 5-2 (Macon)

The HOPE Center
180 Emery Highway
Macon, GA 31217

Terri Smith 478-464-0612
Monday - Friday 8:00 am - 4:30 pm

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

Policies and Procedures

District 6 (Augusta)

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

Chris Morfaw 706-667-4340

*For general information and case management services

Primary care provided by:

Augusta University
Adult Infectious Disease
1120 15th Street
Augusta, GA 30912

Karen Denny 706-721-9512
Monday - Friday 8:00 am - 5:00 pm

*Please call for specific clinic hours

Christ Community Health Services
Augusta Inc.
Dr. Robert Campbell, Dr. Ayers and
Dr. Jeremy Wilson
127 Telfair Street
Augusta, GA 30901

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

Georgia Health Science Hospital and
Clinics - Pediatrics
1120 15th Street
Augusta, GA 30912

Dr. Chitra Mani 706-721-4725
Monday & Wed. 8:30 am - 12:00 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

Karon Bush 706-321-6420
Monday - Friday 8:00 am - 5:00 pm

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

Brendon Hudson 229-931-2514
8:00 am - 5:00 pm on:
1st Tuesday and Thursday of the month
2nd and 3rd Tues. and Wednesday of the month
4th Tuesday of the month

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

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

Policies and Procedures

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

Brendon Hudson 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

John Rogers, RN 229-391-9281
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

John Rogers, RN 229-245-8711
Monday – Thursday 8:00 am - 2:30 pm
Fridays 8:00 am - 2:30 pm

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

District 8-2 (Albany)

Thomasville Office
14540 US. 19 South; Suite 1,
Thomasville, GA 31758

Debra Wallace 229-227-2640
1st, and 3rd Friday (Clinical Services)
Tues – Thurs (Case Management Services)
7:30 am - 6:00 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

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

Jocelyn Cooper 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

District 9-1 (Savannah-Brunswick)

Chatham CARE Center
107 B Fahm Street
Savannah GA 31401

Delores Broden 912-651-2253
Monday - Friday 7:30 am - 6:00 pm

Policies and Procedures

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

Willeen Johnson 912-264-3236
Monday - Friday 8:00 am - 5:00 pm

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

Rhonda Roberts 912-876-5085 or
1-877-221-6959
Mon. - Wed. by appointment only

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

District 9-2 (Waycross)

Bulloch Wellness Center
3 West Altman Street
Statesboro, GA 30458

Shelby Freeman 912-764-2402 or
1-800-796-6213
Monday - Friday 8:00 am - 5:00 pm

Coffee Wellness Center
1003 Shirley Avenue
Douglas, GA 31533-2123

Amanda Coffee 912-389-4586 or
1-866-808-7828
Monday - Friday 8:00 am - 5:00 pm

Toombs Wellness Center
714 North West Broad St.
Lyons, GA 30436

Shelby Freeman 912-764-2402 or
912-526-6488*
2nd and 4th Friday (*Only on clinic days)
8:00 am - 5:00 pm

Ware Wellness Center
1123 Church St.
Waycross, GA 31501

Shelby Freeman 912-389-4586
Once a month 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.
345 N. Harris Street
Athens, GA 30601

Ada Figueroa-Monell 706-583-2772 or
1-877-807-6260
Mon./Wed./Thurs. 8:00 am - 5:00 pm
Tuesday 8:00 am - 7:00 pm
Friday 8:00 am - 2:00 pm

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

Policies and Procedures

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	Kent Montgomery (404) 870-7794 kent.montgomery@aidatlanta.org Jenetter Richburg (404) 870-7784 jenneter.richbug@aidatlanta.org Josh Turner, Health Center Manager (404) 870-7746 josh.turner@aidatlantna.org Toyshebia Napper, ADAP Case Manager (404)-870-7814 Toyshebia.napper@aidatlanta.org Stephanie Williams, Patient Benefits Specialist (404) 870-7822 Stephanie.williams@aidatlanta.org Priscilla Smith, ADAP Case Manager (404) 870-7807 Priscilla.smith@aidatlanta.org Front Desk line: (404) 870-7700 (800) 551-2728	Liz Acar, Director (404) 870-7724 liz.acar@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	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	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

Policies and Procedures

District/ Agency	ADAP/HICP Contact	District/Agency Director
Grady IDP HICP	<p>Mary Etay (404) 616-6760 mdetay@gmh.edu</p> <p>Stacy Bolling (404) 616-6121 sbolling@gmh.edu</p> <p>D. Marie Howard (404) 616-6300 dmhoward@gmh.edu</p> <p>Taj Woods (404) 616-0660 tkwoods@gmh.edu</p> <p>Ryan Woodbury (404) 616-6302 rawoodbury@gmh.edu</p> <p>Kristin Lee Care Resource Coordinator knlee@gmh.edu (404) 616-2426 Fax: 404-489-6017</p> <p>Main phone line (404) 616-9776 Fax: (404) 616-9790</p>	<p>Family and Youth Clinic Shellie Bigelow, Social Work Supervisor (404) 616-6243 sbigelow@gmh.edu</p> <p>Lisa Curtin (404) 616-9795 lcurtin@gmh.edu</p> <p>Antoine Jones (404) 616-9789 Ajones12@gmh.edu</p>
<p>1-0 Athens Specialty Care Clinic 345 N. Harris Street, Suite # 100 Athens, GA 30601</p>	<p>Kim Wasley (706) 425-2940 kimberly.wasley@dph.ga.gov</p> <p>Lacey Payne (706) 425-2938 Lacey.payne@dph.ga.gov</p> <p>Patrick Reilly (706) 425-2941 patrick.reilly@dph.ga.gov</p> <p>Andrea Carey (706) 552-4539 andrea.carey@dph.ga.gov</p> <p>Fax: (706) 425-2936</p>	<p>Deborah Swinford (706) 425-2943 deborah.swinford@dph.ga.gov</p>

Policies and Procedures

District/ Agency	ADAP/HICP Contact	District/Agency Director
1-1 Rome Northwest Georgia Specialty Care 16 East 12 th 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
1-2 Dalton The Living Bridge Center 800 Professional Blvd. Dalton, GA 30720	Donnie Gillum (706) 281-2205 donnie.gillum@dph.ga.gov Main phone line: (706) 281-2360 Fax: (706) 281-2390	Jeff Vollman, Director (706) 281-2350 jeffery.vollman@dph.ga.gov
2-0 Gainesville Hall County Health Department 1290 Athens Street Gainesville, GA 30507	Karla Henriquez (770) 535-5801 karla.henriquez@dph.ga.gov Fax: (770) 535-5743	David Donaldson (770) 735-5877 david.donaldson@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 Capstone Health at Cobb & Douglas Public Health 1650 County Services Parkway Marietta, GA 30008-4009	Stephanie Willey Stephanie.willey@dph.ga.gov (770) 514-2371 Pamela Orr Pamela.Orr@dph.ga.gov (770) 372-3434 ext. 2544 Raechelle Garner Raechelle.Garner@dph.ga.gov (770) 514-2745 Casey Messer (770) 514-2746 casey.messer@dph.ga.gov Fax: (770) 514-2806	Tamarra (Tarai) Kemp-Brown, Grant's Specialist (770) 514-2817 tamarra.kemp-brown@dph.ga.gov

Policies and Procedures

District/ Agency	ADAP/HICP Contact	District/Agency Director
3-2 Fulton Fulton County Department of Health and Wellness 99 Jesse Hill Jr. Drive, SE Atlanta, GA 30303	Angela Corbin (404) 613-1267 angela.corbin@fultoncountyga.gov Douglas Bell (404) 613-1564 douglas.bell@fultoncountyga.gov Fax: (404) 730-1520	Wanda Smith (404) 613-1458 wanda.smith@fultoncountyga.gov Ruby Hardy (404) 613-1410
3-3 Clayton Clayton County Board of Health 1117 Battlecreek Rd Jonesboro, GA 30236 Main: (678) 610-7199	Deven Mann (678) 479-2202 deven.mann@dph.ga.gov Carolyn Smith (678) 610-7563 Carolyn.Smith@aidatlanta.org Fax: (770) 603-4178	Hawa Kone Ryan White Program Coordinator (678) 479-2209 Fax: (770) 603-4178 Hawa.kone@dph.ga.gov George Webb Peer Educator (678) 610-7199 George.webb@dph.ga.gov George Wright Patient Navigator (678) 610-7199 George.wright@dph.ga.gov
3-4 Positive Impact Health Centers 3350 Breckinridge Blvd Ste. 200 Duluth Ga. 30096	GeGe Emile (678) 990-6424 gege.emile@pihcga.org Myrtha Volcy (678) 990-6427 Fax #: (770) 962-1291 Marilyn Sharkey (404) 977-5139 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	Vivian Stevenson (404) 508-7984 vivian.stevenson@dph.ga.gov Dr. Christopher Marine (404) 508-7881 christopher.marine@dph.ga.gov Fax: (404) 297-7231	Carolyn Hodge-Armstrong, LCSW Program Coordinator (404) 508-7898 carolyn.hodge-armstrong@dph.ga.gov

Policies and Procedures

District/ Agency	ADAP/HICP Contact	District/Agency Director
3-6 AIDS Healthcare Foundation (AHF) 5700 Hillandale Drive, Suite 100 Lithonia, GA 30058	Connie Evans (404) 588-4680 connie.evans@aidshealth.org Midtown Location (404) 588-4680 Kenya Wade-Office Assistant/Supervisor- (Mid-town) (470) 639-6581 Kenya.Wade@aidshealth.org Diamond Cook (Mid-town) (404) 588-4680 diamond.cook@aidshealth.org Darlene Prince (Mid-town) (470) 639-6583 darlene.prince@aidshealth.org Fax: (770) 593-8166	Vacant, Regional Director (678) 371-1751 Suzanne Lipe, Pharmacy Manager (770) 808-3705 suzanne.lipe@aidshealth.org Fax: (770) 808-4432
4-0 LaGrange/Griffin Haven of Hope 6 Jefferson Parkway, Suite C Newnan, GA 30263	Tina Adamson (678) 854-8065 tina.adamson@aidatlanta.org Bneikia Robinson (770) 252-5418 bneikia.robinson@aidatlanta.org Fax: (770) 252-5417	Nicole Roebuck, 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) 274-7719 annie.brown@dph.ga.gov Fax: (478) 274-7948	Malela Rozier, HIV Coordinator (478) 274-3012 malela.rozier@dph.ga.gov
5-2 Macon The HOPE Center 135 Macon West Drive Macon, GA 31210	Jessica Baker (478) 464-0612 ext. 120 Jessica.Baker@dph.ga.gov Erin Wust, RN, BSN (478) 464-0612 Erin.Wust@dph.ga.gov Veronica Dumas-Dewberry, RN, BSN (478) 464-0612 ext. 127 Veronica.Dumas-Dewberry@dph.ga.gov Fax: (478) 464-0004	Terri Smith, Program Director The Hope Center (478) 405-7220 terri.smith@dph.ga.gov
6-0 Augusta Georgia Regents University	Brandy Jeffcoat (706) 721-4547	Chris Morfaw, RN, HIV Coordinator (706) 667-4340

Policies and Procedures

District/ Agency	ADAP/HICP Contact	District/Agency Director
<p>1120 15th Street, BP1220 Augusta, GA 30912</p> <p>Christ Community Health Services 127 Telfair Street Augusta, GA 30901</p>	<p>bjeffcoat@gru.edu Fax: (706) 721-0993</p> <p>Ryan Quiller, CMA (706) 396-1480 rquiller@cchaugusta.org Fax: (706) 922-0604</p>	<p>chris.morfaw@dph.ga.gov</p>
<p>7-0 Columbus District Clinical Services 2100 Comer Ave Columbus, GA 31902</p> <p>District Clinical Services P.O. Box 865 1601 N. MLK Jr Blvd, Suite 100 Americus, GA 31709</p>	<p>Makesha Harris (706) 321-6407 makesha.harris@dph.ga.gov</p> <p>Fax: (706) 321-6428</p> <p>Kathryn Arnold (229) 931-2515 kathryn.arnold@dph.ga.gov</p> <p>Fax: (229) 931-7017</p>	<p>Karon Bush, RN, MSN, ACRN District Program Manager (Interim) (706) 321-6420 karon.bush@dph.ga.gov</p>
<p>8-1 Valdosta Adult Health Promotion Clinic 601 North Lee Street Valdosta, GA 31602</p>	<p>LaShawn Graham (Tifton) (229) 391-9281, ext. 152 lashawn.graham@dph.ga.gov</p> <p>Jennifer J. Bradley (229) 245-8711 jennifer.bradley@dph.ga.gov</p> <p>Linda Beauford (229) 247-8025, ext. 229 linda.beauford@dph.ga.gov</p> <p>Fax: (229) 391-3857</p>	<p>John Rogers, HIV Coordinator (229) 245-8711, ext. 241 john.rogers@dph.ga.gov</p> <p>Teresa Hritz, RN, Infections Disease Coordinator (229) 245-8711, ext. 239 teresa.hritz@dph.ga.gov</p>
<p>8-2 Albany The Rural Clinic 2202 E. Ogleshorpe Albany, GA 31705</p> <p>New Beginnings Program P.O. Box 4935 Albany, Georgia 31706</p>	<p>LaToya Robinson (229) 430-4090 latoya.robinson@dph.ga.gov</p> <p>Fax: (229) 430-5142</p>	<p>Remy Hutchins, ACID Coordinator (229) 430-7870 remy.hutchins@dph.ga.gov</p>

Policies and Procedures

District/ Agency	ADAP/HICP Contact	District/Agency Director
9-1 Savannah/Brunswick Chatham CARE Center 107 B Fahm Street Savannah, GA 31401 Glynn CARE Center 1716 Ellis Street Brunswick, GA 31520 Liberty CARE Center 2747 4 th Street Brunswick, GA 31520	Tenell Davis (912) 651-1986 (Chatham) tenell.davis@dph.ga.gov Willeen Johnson (912) 264-3236 (Glynn) (912) 876-5085 (Liberty) willeen.johnson@dph.ga.gov Main Line: (912) 651-2253 (Chatham) Fax: (912) 651-2365 (Chatham) (912) 264-0813 (Glynn) (912) 876-2037 (Liberty)	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	Letitia Sweet (Waycross) (912) 764-2402 Letitia.sweet@dph.ga.gov Lee Ann Ryle (Bulloch Wellness) (912) 764-2402 Leeann.ryle@doh.ga.gov Amanda Coffee (Coffee Wellness) (912) 389-4586 amanda.coffee@dph.ga.gov Sheryl Lewis (Coffee Wellness) (912) 389-4586 (1-866) 808-7828 sheryl.lewis@dph.ga.gov Shelby Freeman (Toombs Wellness) (912) 764-0782 (1-866) 808-7828 shelby.freeman@dph.ga.gov Fax: (912) 389-4590	Bulloch Wellness Center: Shelby Freeman, MPH, MSW (912) 764-2402 shelby.freeman@dph.ga.gov

Policies and Procedures

District/ Agency	ADAP/HICP Contact	District/Agency Director
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) 686-2812 alissow@emory.edu Dina Delva (404) 686-3280 Fax (404) 686-3390 Dina.Delva@emory.edu Bianca A. Pipien-Jackson (404) 686-1639 Fax (404) 686-3446 Bianca.a.pipien-jackson@emory.edu Patrick L. Black (404) 686-7910 Fax (404) 686-2834 Patrick.l.black@emory.edu Fax: (404) 686-5723	Breggie James, Program Administrator (404) 686-7814 breggie.b.james@emory.edu 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.

[illegible]

For Ryan White Part B Program State Office Staff Only:

Approved by: _____

Denied by: _____

Date Approved: _____

Date Denied: _____



Appendix D: Medication Dispensing Log

Medication Dispensing Log

Clinic Name_____

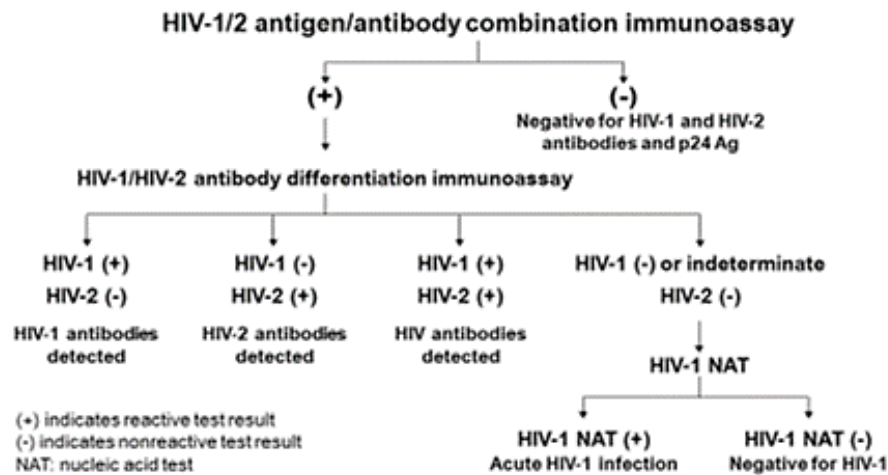
Month_____

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 (Ag/Ab) combination immunoassay* that detects HIV-1 and HIV-2 antibodies and HIV-1 p24 antigen to screen for established infection with HIV-1 or HIV-2 and for acute HIV-1 infection. No further testing is required for specimens that are nonreactive on the initial immunoassay.

* **Exception:** As of April 2014, data are insufficient to recommend use of the FDA-approved single-use rapid HIV-1/HIV-2 antigen/antibody combination immunoassay as the initial assay in the algorithm.

2. Specimens with a reactive Ag/Ab combination 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 antibody immunoassay that differentiates HIV-1 antibodies from HIV-2 antibodies. Reactive results on the initial Ag/Ab combination 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, undifferentiated.
3. Specimens that are reactive on the initial Ag/Ab combination immunoassay and nonreactive or indeterminate on the HIV-1/HIV-2 antibody differentiation immunoassay should be tested with an FDA-approved HIV-1 nucleic acid test (NAT).
 - A reactive HIV-1 NAT result and nonreactive HIV-1/HIV-2 antibody differentiation immunoassay result indicates laboratory evidence for acute HIV-1 infection.
 - A reactive HIV-1 NAT result and indeterminate HIV-1/HIV-2 antibody differentiation immunoassay result indicates the presence of HIV-1 infection confirmed by HIV-1 NAT.
 - A negative HIV-1 NAT result and nonreactive or indeterminate HIV-1/HIV-2 antibody differentiation immunoassay result indicates a false-positive result on the initial immunoassay.
4. Laboratories should use this same testing algorithm, beginning with an Ag/Ab combination immunoassay, with serum or plasma specimens submitted for testing after a reactive (preliminary positive) result from any rapid HIV test.

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

Policies and Procedures

Test performed	Test results	Final interpretation for provider report	Test results to be reported to public health authorities
1. HIV-1/2 Ag/Ab combination immunoassay	1. Nonreactive	Negative for HIV-1 antigen and HIV-1/HIV-2 antibodies. No laboratory evidence of HIV infection. If acute HIV infection is suspected, consider testing for HIV-1 ribonucleic acid (RNA).	Reporting this test result is not required.
1. HIV-1/2 Ag/Ab combination immunoassay 2. HIV-1/HIV-2 antibody differentiation immunoassay	1. Reactive 2. HIV-1 reactive and HIV-2 nonreactive	Positive for HIV-1 antibodies. Laboratory evidence consistent with established HIV-1 infection is present.	Report test results 1 and 2.
1. HIV-1/2 Ag/Ab combo immunoassay 2. HIV-1/HIV-2 antibody differentiation immunoassay	1. Reactive 2. HIV-1 nonreactive and HIV-2 reactive	Positive for HIV-2 antibodies. Laboratory evidence of HIV-2 infection is present.	Report test results 1 and 2.
1. HIV-1/2 Ag/Ab combination immunoassay 2. HIV-1/HIV-2 antibody differentiation immunoassay 3. HIV-1 RNA assay	1. Reactive 2. Nonreactive or indeterminate 3. RNA not detected	HIV antibodies were not confirmed and HIV-1 RNA was not detected. No laboratory evidence of HIV-1 infection. Follow-up testing for HIV-2 should be performed if clinically indicated.	Reporting this test result is not required.
1. HIV-1/2 Ag/Ab combination immunoassay 2. HIV-1/HIV-2 antibody differentiation immunoassay 3. HIV-1 RNA assay	1. Reactive 2. Nonreactive 3. RNA detected	Positive for HIV-1. Laboratory evidence consistent with acute HIV-1 infection is present.	Report test results 1, 2, and 3.
1. HIV-1/2 Ag/Ab combination immunoassay 2. HIV-1/HIV-2 antibody differentiation immunoassay 3. HIV-1 RNA assay	1. Reactive 2. Indeterminate 3. RNA detected	Positive for HIV-1 antibodies. Laboratory evidence of HIV-1 infection confirmed by HIV-1 RNA.	Report test results 1, 2, and 3.
1. HIV-1/2 Ag/Ab combination immunoassay 2. HIV-1/HIV-2 antibody differentiation immunoassay	1. Reactive 2. HIV-1 and HIV-2 reactive	Positive for HIV antibodies. Laboratory evidence of HIV infection is present. HIV antibodies could not be differentiated as HIV-1 or HIV-2. Additional testing for HIV-1 RNA or HIV-2 RNA should be performed if clinically indicated.	Report test results 1 and 2.
1. HIV-1/2 Ag/Ab combination immunoassay 2. HIV-1/HIV-2 antibody differentiation immunoassay	1. Reactive 2. Nonreactive or indeterminate	HIV-1 antibodies were not confirmed and HIV-1 RNA testing was not performed. Testing of this specimen is incomplete. Follow-up testing for HIV antibodies and HIV-1 RNA is recommended as soon as possible.	Report test results 1 and 2.

Quick Reference Guide—Laboratory Testing for the Diagnosis of HIV Infection: Updated Recommendations (Full recommendations available at <http://stacks.cdc.gov/view/cdc/23447>)

Policies and Procedures

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 AND HIV/AIDS testing sites 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

Date Form Completed: <input type="text"/> / <input type="text"/> / <input type="text"/>		State # (GDPH Use Only): <input type="text"/>	
I. Patient Name (last name, first name, and middle initial) and Address.			
Patient's Name: <input type="text"/>		Alias/Maiden: <input type="text"/>	Phone No.: <input type="text"/>
Current Address: <input type="text"/>	City: <input type="text"/>	County: <input type="text"/>	State: <input type="text"/> ZIP Code: <input type="text"/>
Counseling & Testing No. <input type="text"/>	Other ID No. <input type="text"/>	Social Security Number (SSN): <input type="text"/>	Country: <input type="text"/>
Type (e.g. Ryan White, TB, ETC) <input type="text"/>			
II. Demographic Information			
Diagnostic Status at Report: <input type="checkbox"/> HIV infection (not AIDS) <input type="checkbox"/> AIDS	Date of Birth: Month <input type="text"/> Day <input type="text"/> Year <input type="text"/>	Sex at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	Current Gender Identity: <input type="checkbox"/> Male <input type="checkbox"/> Transgender <input type="checkbox"/> Female <input type="checkbox"/> Male to Female <input type="checkbox"/> Female to Male
Country of Birth: <input type="text"/> <input type="checkbox"/> Unknown	Alias Date of Birth: Month <input type="text"/> Day <input type="text"/> Year <input type="text"/>	Vital Status: <input type="checkbox"/> Alive <input type="checkbox"/> Dead <input type="checkbox"/> Unknown	Date of Death: Month <input type="text"/> Day <input type="text"/> Year <input type="text"/> State of Death: <input type="text"/>
Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian / Other Pacific Islanders <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Unknown		Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Unknown	
Residence at Diagnosis			
Address: <input type="text"/>		City: <input type="text"/>	
State/Country: <input type="text"/>		County: <input type="text"/>	ZIP Code: <input type="text"/>
Residence of Diagnosis for: <input type="checkbox"/> HIV <input type="checkbox"/> AIDS		<input type="checkbox"/> Same address as current address	
III. Facility			
<input type="checkbox"/> AIDS diagnosis <input type="checkbox"/> HIV diagnosis		Facility of Diagnosis: <input type="text"/>	
Address: <input type="text"/>	City: <input type="text"/>	County: <input type="text"/>	State/Country: <input type="text"/> ZIP Code: <input type="text"/>
Provider Name: <input type="text"/>			Provider Specialty: <input type="text"/>
Provider Phone No. <input type="text"/>		Patient's Medical Record No. <input type="text"/>	
Person Completing Form: <input type="text"/>			Phone No. <input type="text"/>
Facility of Person Completing Form (If different from Diagnostic facility): <input type="text"/>			
Address: <input type="text"/>		City: <input type="text"/>	County: <input type="text"/> Zip code: <input type="text"/>

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IV. Patient History									
Preceding the first positive HIV antibody test or AIDS diagnosis, this patient had (respond to all categories):									
• Sex with male					YES	NO	UNK.		
• Sex with female					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
• Injected non-prescription drugs					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
• HETEROSEXUAL relations with any of the following: Intravenous/injection drug user					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Bisexual male					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Person with AIDS or documented HIV infection, risk not specified					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
• Received transfusion of blood/blood components (other than clotting factor) (document reason in the Comments section) First date received: _____ Last date received: _____					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
• Worked in a healthcare or clinical laboratory setting specify occupation and setting (if applicable): <input type="checkbox"/> Other risk <input type="checkbox"/> Transplant <input type="checkbox"/> Received clotting factor describe other risk: _____					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

V. DOCUMENTED LABORATORY DATA							
HIV Antibody Tests at Diagnosis (FIRST positive test)							
	+	-	Indet	Mon	DAY	YR	
HIV-1 EIA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
HIV-1/2 EIA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
HIV-1 Western Blot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
HIV Ag/Ab Combo EIA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Other (IFA, etc.) Specify	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
HIV-1/2 Multispot	HIV 1 +	HIV 2 +	Both Undiff.	Neither Neg.			
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Earliest Positive HIV Detection							
<input type="checkbox"/> Qual PCR DNA <input type="checkbox"/> p24 antigen							
<input type="checkbox"/> Qual PCR RNA <input type="checkbox"/> NAAT							
CD4 Count							
	cells/μl	%	Mon	DAY	YR		
At or closest to HIV diagnosis							
First <200 or <14% OR at first AIDS OI							
Detectable HIV Viral Load							
	Type	Copies/mL	Mon	DAY	YR		
Earliest							
Most Recent							
Specify Type: (Please Circle) 1-NASBA, 2-RT-PCR (standard), 3-RT-PCR (ultrasen), 4-bDNA-v. 2, 5-bDNA-v. 3			Mon	DAY	YR		
Physician Diagnosis: If HIV lab tests were not documented, is HIV diagnosis documented by a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No							

VI. TREATMENT			
	Yes	No	Unk
Is patient aware of HIV/AIDS Infection?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Receiving or has been referred for HIV medical services?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Receiving or has been referred for Substance Abuse services?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Receiving Anti-retroviral therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Current Co-Infection?	Date of Diagnosis.		
<input type="checkbox"/> Hepatitis (B or C)	Date: _____		
<input type="checkbox"/> TB	Date: _____		
<input type="checkbox"/> Gonorrhea/ Chlamydia	Date: _____		
<input type="checkbox"/> Syphilis	Date: _____		
HIV medical Treatment Reimbursed?			
<input type="checkbox"/> None	<input type="checkbox"/> Private Insurance		
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Other		
<input type="checkbox"/> Medicare/Medicaid	<input type="checkbox"/> Unknown		
<input type="checkbox"/> Clinical Trial			

VII. For Female Patient
Is this patient currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
If YES, enter expected date of delivery: _____
This patient is receiving or has been referred for gynecological or obstetrical services: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
If YES, enter OB/GYN: _____
Has this patient delivered live-born infant(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
If YES, enter Name and DOB closest to HIV/AIDS diagnosis: Name: _____ DOB: _____

VIII. Comments (Please list any AIDs Related Opportunistic Infections, test, etc...)

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SENDSS Portal HIV/AIDS Confidential Case Report Screenshot

Georgia Adult HIV/AIDS Co... x +

https://sendss.state.ga.us/sendss/HIV_REPORTING.hiv_case_entry?pStage=6

Georgia Adult HIV/AIDS Confidential Case Report Form

(Patients ≥ 13 years of age at time of diagnosis)

Patient Identification

Patient Name

First Name: Middle Name/ MI:
Last Name: Maiden Name:

Alternate Name(s) (shown Last, First)

Please enter each alias (Limit 5) one at a time and click on the "Add" button

Alias Name (First, Last):

Address Type:

Current Street Address:

Phone:

Country:

State:

City:

County:

Zip:

Medical Record #:

SSN:

DL #:

Prison ID:

Counseling & Testing #:

Patient Demographics

Sex Assigned at Birth: ☐ Male ☐ Female ☐ Unknown

Country of Birth:

Date of Birth:

Alias Date of Birth:

Vital Status: ☐ 1 - Alive ☐ 2 - Dead

Date of Death:

State of Death:

Current Gender Identity:

Ethnicity:

Expanded Ethnicity:

☐ American Indian/ Alaska Native ☐ Asian

☐ Black/ African American ☐ Native Hawaiian/Pacific Islander

☐ White ☐ Unknown

Race: ☐ ☐ ☐ ☐ ☐

Expanded Race:

Facility Providing Information

Provider Facility and Address:

► Add/ Edit Facility Address

Facility Name:

Street Address:

Country:

State:

City:

Policies and Procedures

Appendix G: Georgia ADAP Formulary

BRAND NAME	GENERIC NAME
<i>NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTI's)</i>	
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)
Videx, Videx EC**	Didanosine/EC
Zerit**	Stavudine (d4T)
Ziagen	Abacavir (ABC)
<i>NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NNRTI's)</i>	
Intelence	Etravirine (TMC)
Sustiva	Efavirenz (EFV)
Viramune, Viramune XR	Nevirapine (NVP)
Edurant	Rilpivirine (RPV)
<i>PROTEASE & CYP3A INHIBITORS</i>	
Aptivus	Tipranavir (TPV)
Crixivan	Indinavir (IDV)
Invirase	Saquinavir (SQV)
Kaletra	Lopinavir/Ritonavir
Lexiva	Fosamprenavir (FPV)
Norvir	Ritonavir
Prezista	Darunavir (DRV)
Reyataz	Atazanavir (ATV)
Viracept	Nelfinavir (NFV)
Evotaz	Atazanavir/Cobicistat
Prezcobix	Darunavir/Cobicistat
<i>FUSION INHIBITOR</i>	
Fuzeon**	Enfuvirtide (ENV)
<i>INTEGRASE INHIBITOR(INSTI)</i>	
Isentress, Isentress HD	Raltegravir (RAL)
Tivicay	Dolutegravir (DTG)
<i>CCR5 ENTRY INHIBITOR</i>	
Selzentry***	Maraviroc (MVC)
<i>COMBINATION ANTIRETROVIRALS</i>	
Atripla	Efavirenz/ Emtricitabine/ Tenofovir
Complera	Emtricitabine/Rilpivirine/Tenofovir
Genvoya	Elvitegravir/Cobicistat/Emtricitabine/TAF
Odefsey	Emtricitabine/Rilpivirine/TAF
Stribild	Elvitegravir/Cobicistat/Emtricitabine/Tenofovir
Triumeq	Dolutegravir/Abacavir/Lamivudine
<i>ANTIVIRALS</i>	
Famvir*	Famciclovir
Valcyte*	Valganciclovir
Valtrex*	Valacyclovir

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

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HEPATITIS C PROGRAM MEDICATIONS	
BRAND NAME	GENERIC NAME
Daklinza	Daclatasvir
Epclusa	Sofosbuvir/Velpatasvir
Harvoni	Ledipasvir/Sofosbuvir
Mavyret	Glecaprevir/Pibrentasvir
Sovaldi	Sofosbuvir
Technivie	Ombitasvir/Paritaprevir/Ritonavir
Viekira Pak	Ombitasvir/Paritaprevir/Ritonavir/Dasabuvir
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:	
<i>Client/Caregiver:</i>	
1) Patient is willing to take (or caregiver to administer) medications as directed.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2) Patient has prior evidence of adherence to therapy and medical care; and prescriber has reasonable expectation that adherent behavior will continue.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3) Patient's home has sufficient storage at the proper temperature.	<input type="checkbox"/> Yes <input type="checkbox"/> No
DRUGS REQUESTED & REQUIRED INFORMATION:	
<i>Please complete the corresponding section for the specific drugs requested and check the appropriate boxes, or supply the response/supporting documentation.</i>	
<input type="checkbox"/> Fuzeon (Enfuvirtide)	
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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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? <i>(If yes, please provide documentation.)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<small><i>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).</i></small>	
<input type="checkbox"/> 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:	

Edited 3/21/2018

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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:

☐ **Videx (Didanosine)**

1) Current antiretroviral regimen:

2) Length of time on current regimen:

3) Reason for continuing or adding Videx to the regimen:

4) Please attach copies of the most recent viral load, CD4 count and all available resistance testing.

☐ **Zerit (Stavudine)**

1) Current antiretroviral regimen:

2) Length of time on current regimen:

3) Reason for continuing or adding Zerit to the regimen:

4) Please attach copies of the most recent viral load, CD4 count and all available resistance testing.

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

<input type="checkbox"/> Harvoni (Ledipasvir-sofosbuvir)	<input type="checkbox"/> with Ribavirin or	<input type="checkbox"/> without Ribavirin
<input type="checkbox"/> Daklinza (Daclatasvir) plus Sovaldi (Sofosbuvir)	<input type="checkbox"/> with Ribavirin or	<input type="checkbox"/> without Ribavirin
<input type="checkbox"/> Epclusa (Velpatasvir-Sofosbuvir)	<input type="checkbox"/> with Ribavirin or	<input type="checkbox"/> without Ribavirin
<input type="checkbox"/> Zepatier (Elbasvir-Grazoprevir)	<input type="checkbox"/> with Ribavirin or	<input type="checkbox"/> without Ribavirin
<input type="checkbox"/> Technivie	<input type="checkbox"/> with Ribavirin or	<input type="checkbox"/> without Ribavirin
<input type="checkbox"/> VIEKIRA PAK	<input type="checkbox"/> with Ribavirin or	<input type="checkbox"/> without Ribavirin
<input type="checkbox"/> Mavyret (Glecaprevir-Pibrentasvir)		
<input type="checkbox"/> 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:

Georgia ADAP Application for Prior Approval Medications

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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	
9) Hepatitis C Stage: <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> compensated cirrhosis <input type="checkbox"/> decompensated cirrhosis	
- Please check the lab performed within the last 12 months and include a copy:	
<input type="checkbox"/> Liver Biopsy	<input type="checkbox"/> FIB-4 Calculation <input type="text"/>
<input type="checkbox"/> MELD or Child-Pugh Score	<input type="checkbox"/> Non-Invasive Biomarker Testing
10) Does the client have a history of Hepatitis C treatment? <input type="checkbox"/> Yes <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>NOTE: Providers must submit results of the test of cure Hepatitis C Viral Load (12-weeks following treatment).</i>	
Prescriber Information:	
Provider Name (Last, First, M):	Phone: <input type="text"/>
Email: <input type="text"/>	Signature: <input type="text"/>

Georgia ADAP Application for Prior Approval Medications

Request Determination:	
Date Received: <input type="text"/>	Date of Decision: <input type="text"/>
<input type="checkbox"/> Request approved <input type="checkbox"/> Request Denied	
Medical Advisor (Last, First, M): <input type="text"/>	
Phone: <input type="text"/>	Email: <input type="text"/>
Medical Advisor/ Prescriber Signature: <input type="text"/>	
Comments/Additional Information or Instructions:	
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.hevguidelines.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	

Policies and Procedures

Appendix I: ADAP Contract Pharmacy (ACP) Network

Pharmacy Name	Address	Phone	PIC	Delivery	Hours of Operation
Arrowhead Healthmart	188 Upper Riverdale Rd Suite C Jonesboro, GA 30236	770-603-5555	Ola Reffell	N/A	M-F: 10-6pm Sat: 12-3pm
Barnes Drug Store	200 S. Patterson Street Valdosta, GA 31601	229-242-4743	Ben Elliott	N/A	M-F: 9-6pm
Barney's Pharmacy	2604 Peach Orchard Rd, Suite 300, Augusta, GA 30906	706-798-5645	Ashley London	Local Delivery Available	M-F: 9-7pm Sat: 9-4pm
Chatham County Care Center Pharmacy	107 B Fahm Street Savannah, GA 31401	912-651-2238	Pachia Dixon	N/A	M-F: 9-5pm
Cobb County Board of Health Pharmacy	1650 County Services Pkwy Marietta, GA 30008	770-514-2345	Selina Moon	N/A	M-F: 8am- 5:30pm
Community Health Pharmacy	2100 Comer Ave. Columbus, GA 31904	706-321-3700	Debbie Conkle	N/A	M-F: 8:30am- 5pm
Dart Drugs and Surgical	1101 Memorial Drive Dalton, GA 30720	706-278-1900	Jim Elrod	N/A	M-F: 9-7pm Sat: 9am-3pm
East Marietta Drugs	1480 Roswell Road Marietta, GA 30062	770-973-7600	Pam Marquess	\$2 Delivery fee w/in 5 mi.	M-F: 9-6pm Sat: 9:30am- 1:30pm
Huff's Drugs (Purvis)	136 Industrial Blvd. Ellijay, GA 30540	706-635-7931	Steven Purvis	N/A	M-F: 8:30am- 6pm
Lacey Drug Company	4797 South Main St. Acworth, GA 30101	770-974-3131	Ben Flanagan	\$5 Delivery fee w/in 5 mi.	M-S: 8-7pm Sun: 2-6pm
Norcross Pharmacy	510-A Beaver Ruin Rd Norcross, GA 30071	770-448-2288	Geri Hankla	Delivery Available	M-F: 9-7pm Sat: 9-1pm
Parkway Pharmacy	4700 Battlefield Parkway Suite 110, Ringgold, GA 30736	706-866-8475	Jinna Brown	N/A	M-F: 8:30am- 5:30pm
Rainbow Drug Store	4319 New Jesup Hwy. Brunswick, GA 31520	912-265-5040	Daniel Griffis	N/A	M-F: 9am- 7:30pm Sat: 9am-6pm
Scott's Pharmacy #1	635 Pio Nono Ave. Macon, GA 31204	478-742-3098	Bryan Scott	Delivery w/in 3-5 miles	M-F: 9-6pm Sat: 9am-1pm
Wayfield Pharmacy	3050 Martin Luther King Jr. Dr, Unit H, Atlanta, GA 30311	404-699-9000	Bibi Nwabude	Free Delivery w/in 30 miles	M-F: 9-7pm Sat: 10-2pm
Woodstock Pharmacy	8612 Main Street Woodstock, GA 30188	770-926-6478	Pam Marquess	Free Delivery <5mi; \$5 fee > 5miles	M-F: 9-6pm Sat: 9am-2pm
Wynn's Pharmacy	566 S. Eighth Street Griffin, GA 30224	770-227-9432	Drew Miller	N/A	M-F: 8:30am- 5pm

Policies and Procedures

STATEWIDE DELIVERY PHARMACIES

Pharmacy Name	Address	Phone	PIC	Delivery	Hours of Operation
Community, A Walgreens Pharmacy	1874 Piedmont Ave. NE, Ste. 100 A, Atlanta, GA 30324	404-733-6800	Henry Webster	Free Delivery	M-F: 8-6pm Sat: 9-12pm
Curant Health, (formerly HealthStat)	200 Technology Ct SE, Bldg 200, Ste. B, Smyrna, GA 30082	770-437-8040	Paco Patel	Free Delivery	M-F: 8:30-5:50pm
Express Drugs	212 Edgewood Ave. Atlanta, GA 30303	404-688-2211	Gholam Bakhtiari	Free Delivery	M-F: 8-6pm Sat: 9-4pm
Market Pharmacy	209 Edgewood Ave. Atlanta, GA 30303	404-524-8888	Roger Naik	Free Delivery	M-F: 9am-5:45pm Sat: 10-2pm

RESTRICTED PHARMACY

Pharmacy Name	Address	Phone	PIC	Delivery	Hours of Operation
Grady IDP Pharmacy	341 Ponce De Leon Atlanta, GA 30308	404-616-9715 404-616-6290	Kay Woodson	N/A	M-F: 8-5pm

ONLY GRADY CLIENTS CAN UTILIZE GRADY IDP PHARMACY

Revised: 8/17

Policies and Procedures

Appendix J: 2018 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

2018 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	<= \$12,140	to \$12,261 \$18,210	to \$18,331 \$24,280	to \$24,401 \$30,350	to \$30,471 \$36,420	to \$36,541 \$42,490	to \$42,611 \$48,560
2	<= \$16,460	to \$16,625 \$24,690	to \$24,855 \$32,920	to \$33,085 \$41,150	to \$41,315 \$49,380	to \$49,545 \$57,610	to \$57,775 \$65,840
3	<= \$20,780	to \$20,988 \$31,170	to \$31,378 \$41,560	to \$41,768 \$51,950	to \$52,158 \$62,340	to \$62,548 \$72,730	to \$72,938 \$83,120
4	<= \$25,100	to \$25,351 \$37,650	to \$37,901 \$50,200	to \$50,451 \$62,750	to \$63,001 \$75,300	to \$75,551 \$87,850	to \$88,101 \$100,400
5	<= \$29,420	to \$29,714 \$44,130	to \$44,424 \$58,840	to \$59,134 \$73,550	to \$73,844 \$88,260	to \$88,554 \$102,970	to \$103,264 \$117,680
6	<= \$33,740	to \$34,077 \$50,610	to \$50,947 \$67,480	to \$67,817 \$84,350	to \$84,687 \$101,220	to \$101,557 \$118,090	to \$118,427 \$134,960
7	<= \$38,060	to \$38,441 \$57,090	to \$57,471 \$76,120	to \$76,501 \$95,150	to \$95,531 \$114,180	to \$114,561 \$133,210	to \$133,591 \$152,240
8	<= \$42,380	to \$42,804 \$63,570	to \$63,994 \$84,760	to \$85,184 \$105,950	to \$106,374 \$127,140	to \$127,564 \$148,330	to \$148,754 \$169,520
9	<= \$46,700	to \$47,167 \$70,050	to \$70,517 \$93,400	to \$93,867 \$116,750	to \$117,217 \$140,100	to \$140,567 \$163,450	to \$163,917 \$186,800
10	<= \$51,020	to \$51,530 \$76,530	to \$77,040 \$102,040	to \$102,550 \$127,550	to \$128,060 \$153,060	to \$153,570 \$178,570	to \$179,080 \$204,080
+1	\$4,320	\$6,480	\$8,640	\$10,800	\$12,960	\$15,120	\$17,280

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

Policies and Procedures

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 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. 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.

Application Date

Ryan White Application

Eligibility Criteria

Applicant must have the following information before proceeding with application:

Proof of HIV Diagnosis

Proof of Income

Proof of Georgia Residency

2018 FEDERAL POVERTY GUIDELINES									
Annual Income Ranges									
FAMILY SIZE	A	B	C	D	E	F	G		
	<100%	101-150%	151-200%	201-250%	251-300%	301%-350%	351%-400%		
1	<= \$12,140	to \$12,261	to \$18,331	to \$24,401	to \$30,471	to \$36,541	to \$42,611		
		to \$18,210	to \$24,280	to \$30,350	to \$36,420	to \$42,490	to \$48,560		
2	<= \$16,460	to \$16,625	to \$24,855	to \$33,085	to \$41,315	to \$49,545	to \$57,775		
		to \$24,690	to \$32,920	to \$41,150	to \$49,380	to \$57,610	to \$65,840		
		to \$20,988	to \$31,378	to \$41,768	to \$52,158	to \$62,548	to \$72,938		
3	<= \$20,780	to \$31,170	to \$41,560	to \$51,950	to \$62,340	to \$72,730	to \$83,120		
		to \$25,351	to \$37,901	to \$50,451	to \$63,001	to \$75,551	to \$88,101		
		to \$37,650	to \$50,200	to \$62,750	to \$75,300	to \$87,850	to \$100,400		
		to \$29,714	to \$44,424	to \$59,134	to \$73,844	to \$88,554	to \$103,264		
5	<= \$29,420	to \$44,130	to \$58,840	to \$73,550	to \$88,260	to \$102,970	to \$117,680		
		to \$34,077	to \$50,947	to \$67,817	to \$84,687	to \$101,557	to \$118,427		
		to \$50,610	to \$67,480	to \$84,350	to \$101,220	to \$118,090	to \$134,960		
		to \$38,441	to \$57,471	to \$76,501	to \$95,531	to \$114,561	to \$133,591		
7	<= \$38,060	to \$57,090	to \$76,120	to \$95,150	to \$114,180	to \$133,210	to \$152,240		
		to \$42,804	to \$63,994	to \$85,184	to \$106,374	to \$127,564	to \$148,754		
		to \$63,570	to \$84,760	to \$105,950	to \$127,140	to \$148,330	to \$169,520		
		to \$47,167	to \$70,517	to \$93,867	to \$117,217	to \$140,567	to \$163,917		
9	<= \$46,700	to \$70,050	to \$93,400	to \$116,750	to \$140,100	to \$163,450	to \$186,800		
		to \$51,530	to \$77,040	to \$102,550	to \$128,060	to \$153,570	to \$179,080		
		to \$76,530	to \$102,040	to \$127,550	to \$153,060	to \$178,570	to \$204,080		
+1	\$4,320	\$6,480	\$8,640	\$10,800	\$12,960	\$15,120	\$17,280		

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.

Before applying or re-certifying for the Georgia Ryan White Program (ADAP or 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/Other Insurance 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 Human Services (DHS) for questions relating to Medicaid is 1-888-295-1769 or via the web at www.compass.ga.gov.

1. Does the client have a Social Security Number?

☐ Yes

☐ 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 the client previously applied for Medicaid, and been denied?

☐ Yes

☐ No

If yes, when?

Is denial being appealed?

☐ Yes

☐ No (Refer to DHS appeal)

7. Has client's physical condition gotten worse since last applied for Medicaid?

☐ Yes (Refer back to Medicaid)

☐ No

8. Has the client applied for Medicaid and been approved for full benefits?

☐ Yes

☐ No

If Yes, please stop here, client is not eligible for ADAP.

If No and only eligible for QMB or SLMB, continue completing the application.

9A. Has the client applied for Medicare Part D plan?

☐ Yes

☐ No

9B. Has the client applied for LIS?

☐ Yes

☐ No

10. Has the client been approved for Full LIS?

☐ Yes

If Yes, not eligible for
ADAP or HICP

☐ No

If No, continue completing
the application

I. PATIENT INFORMATION

Last Name	First Name	Middle Name	Maiden Name	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Address	City	State	Zip Code	County
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Mailing Address (Street, City, State, Zip Code)				
<input type="text"/>				
Home Phone	Mobile Phone	Marital Status	Date of Birth	SSN
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Gender	<input type="text"/> Sex at Birth <input type="text"/>		Ethnicity <input type="radio"/> Non-Hispanic <input type="radio"/> Hispanic	Race <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Asian Subgroup <input type="checkbox"/> Pacific Subgroup <input type="checkbox"/> Hispanic Subgroup
ADAP Status	HICP Status			
<input type="text"/>	<input type="text"/>			
Medicare Co-Pay Assistance	<input type="text"/>			

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

II. CLINICAL INFORMATION

Diagnosis

AIDS Diagnosis Date

☐ AIDS Date
Est?

HIV Diagnosis Date

☐ HIV Date
Est?

CD4 COUNT

Current CD4

Current CD4 Date

☐ NADIR CD4 Count (if
known)

NADIR 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

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
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Total			<input type="text"/>	
Total X 12 Months=			<input type="text"/>	/a year

Change/View Poverty Level

ASSETS		DOCUMENTATION OF INCOME
TYPE	AMOUNT	
Cash on Hand	<input type="text"/>	<input type="checkbox"/> Employment.
Checking Account	<input type="text"/>	<input type="checkbox"/> Social Security Disability Income
Savings Account	<input type="text"/>	<input type="checkbox"/> Retirement Income
Stocks	<input type="text"/>	<input type="checkbox"/> Veterans Benefits
Bonds	<input type="text"/>	<input type="checkbox"/> Interest/Investment Income
Severance Pay	<input type="text"/>	<input type="checkbox"/> No Income
Other	<input type="text"/>	<input type="checkbox"/> Other Income
Total	<input type="text"/>	

NOTE: Total assets cannot exceed \$10,000

Documentation Attached (Please attach documentation on Application tab)

- | | |
|---|--|
| <input type="checkbox"/> Paycheck Stub for last month | <input type="checkbox"/> VA Award Letter |
| <input type="checkbox"/> Signed Employer Statement with Dates | <input type="checkbox"/> Bank Statements |
| <input type="checkbox"/> Tax Return | <input type="checkbox"/> Statement of Support |
| <input type="checkbox"/> Social Security Award Letter | <input type="checkbox"/> Support and Residency Verification Letter |
| Other: | <input type="text"/> |

V. GEORGIA RESIDENCY

- ☐ Currently living in state of Georgia?

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

- | | |
|---|---|
| <input type="checkbox"/> Copy of Client's Utility Bill | |
| <input type="checkbox"/> Copy of Client's Lease/Mortgage Agreement | |
| <input type="checkbox"/> Client is homeless (in Georgia) | <input type="text"/> Name/Location of Shelter |
| <input type="checkbox"/> Georgia Driver's License or Georgia State ID | |
| <input type="checkbox"/> Other (must be Documents defined in policy) | <input type="text"/> |

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

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

<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicaid Spenddown (QMB)	Medicaid #: <input type="text"/> Medicare#: <input type="text"/>
<input type="checkbox"/> Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D	<input type="checkbox"/> Applied for Low Income Subsidy (LIS) "extra help": <input type="checkbox"/> Approved for Full Low Income Subsidy (LIS): <input type="checkbox"/> Approved for Partial Low Income Subsidy (LIS): <input type="checkbox"/> Applying for Medicare Co-Pay Assistance Medicare Part D Plan Company Name: <input type="text"/> <div> <div>Deductible</div> <div>Co-pays</div> <div>Premiums</div> </div> <div> <input type="text"/> <input type="text"/> <input type="text"/> </div>
<input type="checkbox"/> Veterans Benefits	<input type="checkbox"/> Client served in Armed Forces, Reserves, or National Guard
<input type="checkbox"/> Private Health Insurance <input type="checkbox"/> Individual <input type="checkbox"/> Cobra <input type="checkbox"/> Includes Drug Coverage	Insurance Company <input type="text"/> Policy # <input type="text"/> Phone Number of Insurance Company <input type="text"/> RxCompany <input type="text"/> RxBIN <input type="text"/> RxPCN <input type="text"/> RxGroup <input type="text"/> Contact Person <input type="text"/>
<input type="checkbox"/> Has No Insurance	

Change/View Insurance Assessment

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VII. 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 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 #

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 members of the DPH, HIV/AIDS Office to disclose my confidential information to the extent necessary 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.

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 Name (if name not available, write in)

Case Manager Signature

Case Manager Phone Number

Case Manager Fax Number

Case Manager's Comments

Date

Case Manager Email

Enrollment Site

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: Georgia Residency is Complete
 - ☐Proof of Georgia Residency is Attached
- ☐Section VI: Third Party Payer/Insurance Complete
 - ☐Change/View Insurance Assessment Link Completed
 - ☐Private Insurance Enrollment Screening Form
 - ☐Request to Remain on ADAP Form
If Applicable
- ☐Section VII: HICP Information is Complete

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 Screening Worksheet is Complete
 - ☐ 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

Appendix L: Self-Attestation Form

Application Date	
Before applying or re-certifying for the Georgia Ryan White Program (ADAP or HICP), the following Medicaid Screening Worksheet must be completed and attached to the application.	
<p>Please answer the following questions to assist in determining if the client is eligible Medicaid/Other Insurance 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 Georgia Department of Human Services (DHS) is 1-888-295-1769 or via the web www.compass.ga.gov.</p>	
1. Does the client have a Social Security Number?	
<input type="checkbox"/> Yes	<div style="border: 1px solid black; width: 100px; height: 20px; display: inline-block;"></div> <input type="checkbox"/> No
2. What is the current (gross) annual income for client?	
<div style="border: 1px solid black; width: 100px; height: 20px; display: inline-block;"></div>	
3. Is the client a female with minor child(ren) in the home?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Is the client 65 years of age or older?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Is the client disabled?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Has the client previously applied for Medicaid and been denied?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, when? <div style="border: 1px solid black; width: 100px; height: 20px; display: inline-block;"></div>	
If yes, is denial being appealed?	
<input type="checkbox"/> Yes <input type="checkbox"/> No (Refer to DHS to appeal)	
7. Has client's physical condition gotten worse since last applied for Medicaid?	
<input type="checkbox"/> Yes (Refer back to Medicaid) <input type="checkbox"/> No	
8. Has the client applied for Medicaid and been approved for full benefits?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, please stop here, client is not eligible for ADAP.	
If No and only eligible for QMB or SLMB, continue completing the application.	
9A. Has the client applied for a Medicare Part D plan?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
9B. Has the client applied for LIS?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
10. Has the client been approved for Full LIS?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Page 1	
Six Month GA ADAP/HICP Recertification Self-Attestation Form	

Policies and Procedures

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 recertification.

***Required: Most recent Medicaid Status printout.

Last Name	FirstName	Middle Initial/Name	Telephone Number
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
DOB	SSN	Gender	Marital Status
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Race		Ethnicity	<input type="checkbox"/> ADAP Recert Self Attestation Form
<input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> or Other Pacific Islander		<input checked="" type="radio"/> Non-Hispanic <input type="radio"/> Hispanic	ADAP Slot <input type="text"/>
			Medicare Co-Pay Assistance <input type="text"/>

***Required: Attachment of CURRENT LABS

HICP Slot

Diagnosis	AIDS Diaqonsis Date	<input type="checkbox"/> AIDS Date Est?	HIV Diagnosis Date	<input type="checkbox"/> HIV Date Est?
<input type="text"/>	<input type="text"/>		<input type="text"/>	
Current CD4 Count (Within 6 months)	<input type="text"/>	Not	Date	<input type="text"/>
Current Viral Load (Within 6 months)	<input type="text"/>	<input type="checkbox"/> Detectable (ND)	Date	<input type="text"/>

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
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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 change, 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

APPLICABLE ONLY TO HICP CLIENTS WITH EXCHANGE (ACA), COBRA, OR INDIVIDUAL Required: Attach latest premium Notice, notification Responsibility Form, verification 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 verification.

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.

ADAP / CM	Case Manager Name <input type="text"/>	Case Manager Email <input type="text"/>	Case Manager Phone <input type="text"/>
HICP / CM	Case Manager Name <input type="text"/>	Case Manager Email <input type="text"/>	Case Manager Phone <input type="text"/>

Case Manager Signature

Date

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 regarding pharmaceutical coverage equivalent to medications on the ADAP Formulary as well as coverage for other essential medical benefits must be attached.

Policies and Procedures

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?

Page 4



Appendix M: Support & Residency Verification Letter

SUPPORT AND RESIDENCY VERIFICATION LETTER

_____ states that his/her average monthly income is _____.
Client's Name

His/Her means of support and residency are defined below. By signing this form, the client declares that the statement(s) is truthful. If information is found to be falsified, action can be taken up to and including removal from Ryan White supported programs.

Client: If someone else is supporting you, Attach documentation from that individual or organization. If documentation is unavailable, please explain why.

Client: Please explain how you obtain food.

Client: I reside at _____

Client: If you do not have proof of residency in your name, please state where and with whom you live and attach a written statement from the person(s) with whom you live.

Client Signature_____

Notary_____

Sworn to and subscribed before me this _____day of _____ in the year _____.

Appendix N: Statement of Support

STATEMENT OF SUPPORT

COMPLETE THIS FORM IF SOMEONE ELSE PROVIDES SUPPORT FOR YOU.

STATEMENT OF SUPPORT FOR

(NAME OF APPLICANT)

SECTION I – IF SOMEONE ELSE PROVIDES YOU WITH SUPPORT, HAVE HIM/HER FILL OUT THIS FORM AND HAVE HIM/HER SIGN IN SECTION 2.

Name of person providing support

What is your relationship to the applicant?

- ☐ His/Her parent (biological or adoptive)
- ☐ His/Her child (biological or adoptive)
- ☐ Other relative (brother, sister, aunt, uncle, brother-in-law, etc.) Please circle or indicate other

☐ Other (friend, neighbor, etc.) Please circle or indicate other _____

Type of support provided for free or minor charge (check all that apply):

- ☐ Lodging
- ☐ Food
- ☐ Telephone
- ☐ Utilities
- ☐ Other (describe): _____

For what part of the past 12 months did the applicant live in your household? _____.

Please provide the following current contact information.

Mailing address: _____

Address

City, State and Zip Code

Telephone Number

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

Appendix O: Modified Adjusted Gross Income (MAGI) Factsheet

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

Using the Modified Adjusted Gross Income (MAGI) Methodology to Determine Ryan White Part B / ADAP/ HICP Eligibility

What is MAGI?

- It is a method for how income is counted, and how household composition and family size is determined.
- It is based on the federal tax rules for determining adjusted gross income, with some modifications.
- Grantees can utilize the MAGI form to facilitate the process of determining FPL.

Why use MAGI?

- To align eligibility methodologies with other state programs, including Medicaid, in order to encourage collaboration across agencies and facilitate the eligibility determination process for clients.

How does MAGI differ from how the program was determining income prior to 2014?

- One of the main differences is that MAGI does not count child support, Supplemental Income from Social Security (defined in the line item definition table), worker's compensation, food stamps or monetary gifts toward total adjusted gross income.

Georgia Department of Public Health
Monthly Modified Adjusted Gross Income (MAGI) Worksheet: Auto-Calculating

Client Name: Last Name First Name Initial SSN DOB (MM/DD/YY)

Family Size: (incl. Family Size: (incl. Family Size: (incl. Family Size: (incl.

Income Sources		Total Monthly (2) Amount for all Legal Household Members	
Wages, Salaries, Tips, etc. (from W-2)	\$	Pensions & Annuities (Veteran/ Employer Based)	\$
Taxable Interest (from 1099-INT)	\$	Pensions, Retirement or Disability	\$
Tax-Exempt Interest (from 1099-INT)	\$	Rental Real Estate, Partnerships, S Corporations	\$
Ordinary Dividends (from 1099-DIV)	\$	Trusts, RE, S Corporations	\$
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 E)	\$	Disability Income from Social Security	\$
Capital Gains/ Losses (Schedule D)	\$	Supplemental Income from Social Security	\$
Other Gains/ Losses (from 4798)	\$	(SPECIALTY LINE A)	\$
IRA Distributions - Taxable Amount	\$	Other Income (Jury Duty Pay, Gambling, Winnings)	\$
TOTAL COLUMN 1	\$	Child Support Received, Workers Comp, Monetary Gifts (SPECIALTY LINE B)	\$
TOTAL INCOME (Total Column 1 + Total Column 2)	\$	TOTAL COLUMN 2	\$
NON-MAGI (not calculated but required)		Total Monthly (2) Amount for all Legal Household Members	
Educator Expenses	\$	Penalty on Early Withdrawal of Savings	\$
Business Expenses (from 1099-EZ)	\$	Alimony Paid	\$
Health Savings Account (from 1099-MS)	\$	IRA Deduction	\$
Moving Expenses (from 1099-INT)	\$	Student Loan Interest Deduction	\$
Deductible Part of Self-Employment Tax (from 1099-EZ)	\$	Tuition and Fees (from 1099-EZ)	\$
Self-Employed SEP, SIMPLE Plans	\$	Domestic Production Activities (from 1099-INT)	\$
Self-Employed Health Insurance Deduction	\$	TOTAL COLUMN 2	\$
TOTAL ADJUSTMENTS (Total Column 1 + Total Column 2)	\$	TOTAL COLUMN 2	\$
NON-MAGI SUB-TOTAL (Total Adjustments + Specialty Line A + Specialty Line B)	\$	TOTAL COLUMN 2	\$
MAGI (Total Income - Non-MAGI Subtotal)		MAGI (Total Income - Non-MAGI Subtotal)	
FEDERAL POVERTY LEVEL (FPL) (see footnote 1-6)		FEDERAL POVERTY LEVEL (FPL) (see footnote 1-6)	
FEDERAL POVERTY LEVEL (FPL) (see footnote 1-6)		FEDERAL POVERTY LEVEL (FPL) (see footnote 1-6)	
FEDERAL POVERTY LEVEL (FPL) (see footnote 1-6)		FEDERAL POVERTY LEVEL (FPL) (see footnote 1-6)	
FEDERAL POVERTY LEVEL (FPL) (see footnote 1-6)		FEDERAL POVERTY LEVEL (FPL) (see footnote 1-6)	

Figure 1. Ryan White Part B/ ADAP/ HICP MAGI Worksheet introduced April 2014.

The MAGI process of determining income eligibility for Ryan White Part B/ ADAP/ HICP became effective as of April 1, 2014.

All enrollment sites were provided with a copy of the Excel MAGI Worksheet along with the Ryan White Part B/ ADAP/ HICP Policies and Procedures document. The worksheet is self-calculating, meaning it will calculate total gross income and Federal Poverty Level automatically.

Enrollment sites are to use the MAGI Worksheet for all clients when:

- enrolling into the program
- self-attesting (if there are changes to income)
- completing the yearly recertification

The MAGI Worksheet is to be kept in the client's file and submitted with the ADAP/ HICP application, along with proof of income.

Information on what counts as income, and acceptable documentation can be found in the Policies and Procedures document. More detailed examples of documentation can be found in the table attached.

For additional questions regarding the MAGI process and use, please contact your state liaison.

Policies and Procedures

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.	<ul style="list-style-type: none"> 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.	<ul style="list-style-type: none"> 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.	<ul style="list-style-type: none"> 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).	<ul style="list-style-type: none"> Line 9a on Form 1040*
Taxable Refunds of State/Local Income Taxes	Refunds received from state/local income taxes.	<ul style="list-style-type: none"> Line 10 on Form 1040*
Alimony or other Spousal Support Received	Alimony or spousal support received.	<ul style="list-style-type: none"> 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.	<ul style="list-style-type: none"> 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.	<ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> 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.	<ul style="list-style-type: none"> Line 15b on Form 1040*
Pensions & Annuities (Veteran/ Employer Based Pensions, Retirements or disability)	Benefits in the form of pension or annuity payments.	<ul style="list-style-type: none"> 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.	<ul style="list-style-type: none"> Line 26 on Schedule E* Line 17 on Form 1040*
Farm Income or Loss	Income and expenses for self-employed farmers.	<ul style="list-style-type: none"> 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.	<ul style="list-style-type: none"> 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.	<ul style="list-style-type: none"> 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."	<ul style="list-style-type: none"> 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.	<ul style="list-style-type: none"> 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.	<ul style="list-style-type: none"> 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.	<ul style="list-style-type: none"> 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.	<ul style="list-style-type: none"> 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.	<ul style="list-style-type: none"> 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.	<ul style="list-style-type: none"> 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.	<ul style="list-style-type: none"> 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.	<ul style="list-style-type: none"> Line 12 on Schedule SE* Line 27 on Form 1040*
Self Employed SEP, SIMPLE Plans	Self-employment retirement plans.	<ul style="list-style-type: none"> 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.	<ul style="list-style-type: none"> 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.	<ul style="list-style-type: none"> 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.	<ul style="list-style-type: none"> Line 31a on Form 1040*
IRA Deduction	Deductions that apply when a person makes contributions to a traditional IRA.	<ul style="list-style-type: none"> Line 32 on Form 1040*
Student Loan Interest Deduction	Deduction of interest related to repaying a student loan.	<ul style="list-style-type: none"> 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.	<ul style="list-style-type: none"> 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."	<ul style="list-style-type: none"> 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 P: MAGI/ FPL Determination Worksheet

Worksheet Instructions

Modified Adjusted Gross Income (MAGI) Worksheet Instructions

Client Name:	Enter the client's name (last name, first name, middle initial).
SS# (Social Security Number):	Enter the client's social security number.
DOB (Date of Birth):	Enter the client's date of birth.
Family Size:	There are four spaces for family size: 1-8; 9-16; 17-24; 25-32. Enter the family size of the client in the appropriate space. For example, if the client has a family size of 4, enter the number 4 in the corresponding <u>family size (1-8)</u> space. Leave the other spaces blank.
Income Sources:	If no income is collected by the client for any of the categories, enter \$0.00 as the value.
Non MAGI:	If the client does not have any of these expenses, enter \$0.00 as the value.

Policies and Procedures

MAGI Worksheet for Monthly Income

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: _____ Family Size: _____
 (1-8) (17-24)
 Family Size: _____ Family Size: _____
 (9-16) (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)	\$ -	Rental Real Estate, Partnerships, S Corporations, Trusts, Etc. (Schedule E)	\$ -
Tax Exempt Interest (Form 1099-INT box 8)	\$ -	Farm Income or Loss (Schedule F)	\$ -
Ordinary Dividends	\$ -	Unemployment Income	\$ -
Taxable Refunds of State/Local Income Taxes	\$ -	Retirement Income from Social Security	\$ -
Alimony or other Spousal Support Received	\$ -	Disability Income from Social Security	\$ -
Business Income/ Loss (Schedule C or C-EZ)	\$ -	*Supplemental Income from Social Security (SPECIALTY LINE A)	\$ -
Capital Gain/ Loss (Schedule D)	\$ -	Other Income (Jury Duty Pay, Gambling, Winnings)	\$ -
Other Gains/ Losses	\$ -	*Child Support Received, Workers Comp, Monetary Gifts (SPECIALTY LINE B)	\$ -
IRA Distributions - Taxable Amount	\$ -		
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	\$ -	Domestic 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 Q: Private Insurance Enrollment Screening Form

Georgia Department of Public Health Ryan White Part B Program

Private Insurance Enrollment Screening Form

<div style="border-bottom: 1px solid black; margin-bottom: 5px;"></div> Client Name	<div style="border-bottom: 1px solid black; margin-bottom: 5px;"></div> Client ID#
<div style="border-bottom: 1px solid black; margin-bottom: 5px;"></div> Employee Name	

Enrollment Screening			
Y	N	N/A	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Client was informed about other health insurance options
Date of Encounter:			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Client was referred to a Health Insurance Marketplace Enrollment Assistance Location in their area
Date of Encounter:			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Is the client eligible for insurance through the Health Insurance Marketplace?
Date of Encounter:			If no , is the client's income at or below 99% FPL? Yes <input type="checkbox"/> No <input type="checkbox"/> (If yes, proof of income required. If no, please explain below.) Does the client have a certificate of exemption? Yes <input type="checkbox"/> No <input type="checkbox"/> (If yes, copy of exemption required. If no, please explain below.)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Client will be enrolled or re-certified into Ryan White Part B/ ADAP
Date of Encounter:			If yes , and the client is eligible for a health insurance plan, please explain why in the Notes section. If no , and the client has an income at or below 99% FPL or has a certificate of exemption, please explain why in the Notes section.

Notes:

Client Signature	Date
Employee Signature	Date

Appendix R: 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 27 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 \$405 of drug costs and then 15% up to \$3,750. But they must pay 100% of the coverage gap between \$3,750 and \$5,000.00. This coverage gap is called the "donut hole." After paying \$5,000.00, 65% 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 \$450. 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 \$18,456.00 should apply for LIS *Extra Help*. If they get full *Extra Help* they will not have a "donut hole." They may pay \$3.35 to \$8.35 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 medications 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.

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- 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 (dual eligibles) 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 dual eligibles. They can check their status at www.medicare.gov or talk to a counselor for help.

To avoid a break in coverage, dual eligibles were placed in Medicare Part D plans and should have received letters about the plans they have been assigned. Dual eligibles 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 \$3.30 to \$8.25. 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/HIV/AIDSRes/index.html?redirect=/HIV/AIDSRes/
Information Partners Can Use on: People with Medicare and HIV/AIDS
- <http://www.medicare.gov/Pubs/pdf/10050.pdf>
Medicare and You 2016

Phone Numbers:

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

Appendix S: Request to Remain on ADAP and to Decline other Coverage

BEFORE SIGNING READ THIS DOCUMENT CAREFULLY AND BE SURE YOU UNDERSTAND

You are getting this letter because you can get health coverage through another program (Health Insurance Marketplace, Medicare Part D) but have decided not to obtain coverage. If you decide not to get other coverage and want to keep getting services from the Ryan White Part B Program, including ADAP- Medication Assistance (ADAP), there may be serious consequences.

- Under the Affordable Care Act (ACA), the penalty for not having health insurance in 2018 is \$695 or 2.5% of your yearly household income, whichever is more. The Ryan White Part B Program **will not** help you pay this penalty. You will have to pay the penalty yourself.
- The State ADAP office may assist with Medicare Part D 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 Low-Income Subsidy (LIS). In these cases individuals should carefully consider plans with low premiums. Failure to pay premiums can make Medicare Part D more costly in the future. A 1% increase in premiums will be added for each month a beneficiary was not enrolled in Medicare Part D.
- If you choose to not get health insurance and are enrolled in the Ryan White Part B Program, you will only be able to get medications listed on the ADAP Formulary and only be able to see Ryan White Part B Program doctors and providers.
- If the Ryan White Part B Program does not have enough money to help everyone, there will be people placed on a wait-list. The decision not to select other coverage when available could affect placement on the wait-list.

Initial all of the following:

- _____ I choose not to get health insurance even though I could (includes Marketplace insurance or Medicare Part D coverage).
- _____ I want to keep getting medications from ADAP.
- _____ I understand that the health care network and/or services available to me may be limited by not enrolling in health insurance for which I am eligible.
- _____ I understand that if I am enrolled in ADAP I will only be able to get medications on the ADAP Formulary and only see Ryan White Part B Program doctors and providers.
- _____ I understand that if I do not get health insurance, the Ryan White Part B Program will not pay the penalty.
- _____ If there is an ADAP wait-list in the future, I understand that my choice not to get health insurance will affect my place on the ADAP wait-list.

Review and sign the reverse side.



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I agree that I have completely read this letter and understand the information. By signing below, I agree to the facts and conditions in this document.

Client Name (Please Print)

Date of Birth

Client Signature

Date Signed

Case Manager/ Designated Staff Name

Case Manager/ Designated Staff Signature

Date signed

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Appendix T: 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 U: 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 V: 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 W: 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 <input type="checkbox"/>												
GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender (Male to Female) <input type="checkbox"/> Transgender (Female to Male)	RACE <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/ Other Pacific Islander <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Other	ETHNICITY <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated									
ADAP STATUS IN OTHER STATE: Active <input type="checkbox"/> In-Active <input type="checkbox"/>		PATIENT ASSISTANCE PROGRAM (Have you applied to a PAP?): Yes <input type="checkbox"/> No <input type="checkbox"/>										
		MEDICAID ELIGIBILITY: Pending <input type="checkbox"/> Denied <input type="checkbox"/> N/A <input type="checkbox"/> Is the client receiving Medicaid in another state? Yes <input type="checkbox"/> No <input type="checkbox"/>										
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 <input type="checkbox"/> No <input type="checkbox"/>												
*** 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: <table style="width: 100%;"> <tr> <td>Medication: _____</td> <td>Dosage (mg): _____</td> <td>Last fill date: _____</td> </tr> <tr> <td>Medication: _____</td> <td>Dosage (mg): _____</td> <td>Last fill date: _____</td> </tr> <tr> <td>Medication: _____</td> <td>Dosage (mg): _____</td> <td>Last fill date: _____</td> </tr> </table>				Medication: _____	Dosage (mg): _____	Last fill date: _____	Medication: _____	Dosage (mg): _____	Last fill date: _____	Medication: _____	Dosage (mg): _____	Last fill date: _____
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 X: Medication Override Request Form

Georgia ADAP/HICP/Hepatitis C Medication Override Request Form			
<i>Please upload this form and supporting attachments into CAREWare</i>			
Date of Request:	<input type="text"/>		
Client Name (Last, First, MI):	<input type="text"/>		
ADAP/HICP Slot #:	<input type="text"/>	Recertification Due Date:	<input type="text"/>
Client's Pharmacy:	<input type="text"/>		
Type of Request:	<input type="text"/>	Incident Date:	<input type="text"/>
Travel Departure Date:	<input type="text"/>	Return Date:	<input type="text"/>
		Travel Itinerary Attached?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Number of Refills Requested?	<input type="radio"/> 30 Days <input type="radio"/> 60 Days		
Medication Name & Milligram:	<input type="text"/>		
Have you explored all other sources of medication access prior to this request?			
<input type="checkbox"/> Yes <input type="checkbox"/> No			
Does the client have 90 consecutive days of medication utilization?			
<input type="checkbox"/> Yes <input type="checkbox"/> No			
Last 3 Fill Dates:	Date: <input type="text"/>	Date: <input type="text"/>	Date: <input type="text"/>
Brief Explanation for Request <i>(please attach police/incident report if available):</i>			
<input type="text"/>			
<input type="text"/>			
<input type="text"/>			
<input type="text"/>			
<input type="text"/>			
<input type="text"/>			
DPH Use Only:			
Reviewed By:	<input type="text"/>	Date:	<input type="text"/>
<input type="radio"/> Approved	<input type="radio"/> Denied	PA #:	<input type="text"/>

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Appendix Y: 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 _____



Georgia Department of Public Health
Division of Health Protection
Office of HIV/AIDS