

Before applying for Recertification for the Georgia AIDS Drug Assistance Program (ADAP), the following Medicaid Screening Worksheet must be completed and attached to the application

Please answer the following questions to assist in determining if the client is eligible for Medicaid before applying for the ADAP. Answering **Yes** to any of the questions may indicate that the client is eligible for Medicaid assistance. **The contact number for the Georgia Department of Community Health (DCH) is 404-656-3200.**

1. Does the client have a Social Security Number?
 Yes Please indicate number: _____
 No
2. What is the current (gross) annual income for client? _____
3. Is the client a female with a minor child(ren) in the home?
 Yes
 No
4. Is the client 65 years of age or older?
 Yes
 No
5. Is the client disabled?
 Yes
 No
6. Has client previously applied for Medicaid, and been denied?
 Yes
 No
When? _____
Is denial being appealed? Yes No (Refer to DCH to appeal)
7. Has client's physical condition gotten worse since last applied for Medicaid?
 Yes (Refer to back to DCH)
 No
8. Has the client applied for Medicaid and been approved for full benefits.
 Yes If yes please stop here, client is not eligible for ADAP.
 No If no and only eligible for QMB or SLMB, continue completing the application.
9. Has the client applied for a Medicare Part D plan and LIS?
 Yes
 No
10. Has the client been approved for Full LIS?
 Yes If yes, not eligible for ADAP
 No If no, continue completing the application

**GEORGIA AIDS DRUG ASSISTANCE PROGRAM (ADAP) ELIGIBILITY
RECERTIFICATION FORM**

I. CLIENT SLOT # _____

II. PATIENT INFORMATION

<u>LAST NAME</u>	<u>FIRST NAME</u>	<u>MIDDLE INITIAL</u>	<u>MAIDEN</u>
<u>ADDRESS</u>	<u>CITY</u>	<u>STATE</u>	<u>ZIP CODE</u> <u>COUNTY</u>
<u>MAILING ADDRESS</u>	<u>CITY</u>	<u>STATE</u>	<u>ZIP CODE</u> <u>COUNTY</u>
<u>DATE OF BIRTH</u> ____/____/____	<u>SOCIAL SECURITY #</u> -- -- (IF APPLICABLE)	<u>GENDER</u> <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> TRANSGENDER <input type="checkbox"/> UNKNOWN	<u>TELEPHONE NUMBER</u> #1 () - #2 () -
<u>ETHNICITY</u> <input type="checkbox"/> HISPANIC <input type="checkbox"/> NON-HISPANIC <input type="checkbox"/> UNKNOWN	<u>RACE</u> <input type="checkbox"/> WHITE OR CAUCASIAN <input type="checkbox"/> BLACK OR AFRICAN AMERICAN <input type="checkbox"/> ASIAN <input type="checkbox"/> AMERICAN INDIAN/ALASKA NATIVE <input type="checkbox"/> NATIVE HAWAIIAN or Other PACIFIC ISLANDER <input type="checkbox"/> OTHER <input type="checkbox"/> UNKNOWN	<u>MARITAL STATUS</u> <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED	

III. CLINICAL INFORMATION

CD4 COUNT	VIRAL LOAD
CURRENT: _____ DATE: ____/____/____	CURRENT: _____ DATE: ____/____/____

IV. PHYSICIAN INFORMATION

<u>PRINT NAME</u>	<u>CLINIC NAME</u>
<u>ADDRESS</u>	<u>CITY</u> <u>STATE</u> <u>ZIP</u> () -
<u>PHYSICIAN'S SIGNATURE</u>	<u>PHONE</u>

V. FINANCIAL/INCOME INFORMATION

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

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

NOTE: Total assets cannot exceed \$ 10,000

DOCUMENTATION OF INCOME

Type of Income (indicate all that are applicable):	Documentation Attached:
<input type="checkbox"/> Employment	<input type="checkbox"/> Paycheck Stub for last month <input type="checkbox"/> Signed Employer Statement with Dates <input type="checkbox"/> Tax Return <input type="checkbox"/> Other (Specify):
<input type="checkbox"/> Child Support Payments	<input type="checkbox"/> Court Order/Copy of Check
<input type="checkbox"/> Social Security Disability Income (SSDI)	<input type="checkbox"/> Social Security Award Letter
<input type="checkbox"/> Supplemental Security Income (SSI)	<input type="checkbox"/> SSI Award Letter
<input type="checkbox"/> Veterans Benefits	<input type="checkbox"/> VA Award Letter
<input type="checkbox"/> Interest/Investment Income	<input type="checkbox"/> Bank Statements
<input type="checkbox"/> Other	<input type="checkbox"/> Other (Specify):
<input type="checkbox"/> No Income (Please complete the Support and Residency Verification Letter)	<input type="checkbox"/> Signed Statement of Source of Living Expenses (i.e., Family/Friends, with Witness Signature)

VI. GEORGIA RESIDENCY

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

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

VII. THIRD PARTY PAYER/INSURANCE INFORMATION

<input type="checkbox"/> MEDICAID <input type="checkbox"/> MEDICAID SPENDDOWN (QMB)	MEDICAID #: N/A <input type="checkbox"/>
<input type="checkbox"/> MEDICARE <input type="checkbox"/> PART A <input type="checkbox"/> PART B <input type="checkbox"/> PART D	MEDICARE #: N/A <input type="checkbox"/> Applied for Low Income Subsidy (LIS) "extra help": yes <input type="checkbox"/> no <input type="checkbox"/> Approved for Full Low Income Subsidy (LIS) "extra help" yes <input type="checkbox"/> no <input type="checkbox"/> Approved for Partial Low Income Subsidy (LIS) "extra help" yes <input type="checkbox"/> no <input type="checkbox"/> MEDICARE Part D Plan Company Name: _____ Deductible \$ _____ Co-pays \$ _____ Premiums \$ _____
<input type="checkbox"/> VETERANS BENEFITS	Did the client ever serve in the Armed Forces, Reserves, or National Guard? yes <input type="checkbox"/> no <input type="checkbox"/>
<input type="checkbox"/> PRIVATE HEALTH INSURANCE <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> GROUP <input type="checkbox"/> COBRA INCLUDES DRUG COVERAGE <input type="checkbox"/> YES <input type="checkbox"/> NO	INSURANCE COMPANY: POLICY #: PHONE NUMBER OF INSURANCE COMPANY: () - CONTACT PERSON:
<input type="checkbox"/> NO INSURANCE	

VIII. APPLICANT AGREEMENT

I fully understand that the AIDS Drug Assistance Program is intended for clients with HIV infection who are unable to pay for their medications. 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 services. If I fail to comply with this policy, I fully understand that I can be removed from ADAP.

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

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

 Print Client Name

_____/_____/_____
 Date

 Client Signature

THIS APPLICATION FORM MUST NOT BE ALTERED

IX. CASE MANAGER AGREEMENT

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

Print Case Manager Name

Date

Case Manager Signature

(____)____ - ____

Case Manager Phone Number

COMMENTS: _____

(____)____ - ____

Case Manager Fax Number

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

All applications must include the following information or documentation.	
<input type="checkbox"/> Section I: Patient Information is Complete	<input type="checkbox"/> Medicaid Screening Worksheet is Complete
<input type="checkbox"/> Section II: Clinical Information is Complete	<input type="checkbox"/> Copy of Medicaid/Medicare Card, if applicable
<input type="checkbox"/> Copies of Lab Results (CD4 and/or Viral Load) (Tests must not be more than 6 months old)	<input type="checkbox"/> Copy of Medicare Part D Plan enrollment card (if applicable)
<input type="checkbox"/> Section IX: Waiting List Criteria, if applicable	<input type="checkbox"/> Copy of denial or approval letter for Low Income Subsidy (LIS)
<input type="checkbox"/> Section IV: Financial Information is Complete	<input type="checkbox"/> Application Has Been Signed And Dated By:
<input type="checkbox"/> Proof of Income is Attached	<input type="checkbox"/> Client
	<input type="checkbox"/> Physician
	<input type="checkbox"/> Case Manager
<input type="checkbox"/> Proof of Georgia Residency is Attached	<input type="checkbox"/> Prescriptions & Prescription Memorandum are Attached
	Note: Pilot sites are not required to attach Prescriptions & Prescription Memorandum
<input type="checkbox"/> Case Report is Attached	<input type="checkbox"/> Application is Complete with all required attachments

FOR DHR USE ONLY

DISPOSITION OF APPLICATION	
DATE RECEIVED	<input type="checkbox"/> NO PROOF OF HIV+ STATUS <input type="checkbox"/> INCOME EXCEEDS CURRENT CRITERION <input type="checkbox"/> NO PROOF OF GEORGIA RESIDENCY <input type="checkbox"/> CLIENT HAS INSURANCE (WITH RX COVERAGE) <input type="checkbox"/> CLIENT HAS VA BENEFITS <input type="checkbox"/> CLIENT HAS OTHER PAYOR SOURCE _____ <input type="checkbox"/> CLIENT EXCEEDS MEDICAL ELIGIBILITY CRITERION <input type="checkbox"/> INCOMPLETE APPLICATION* <input type="checkbox"/> WAITING LIST PRIORITY LEVEL: _____
	<input type="checkbox"/> APPROVED <input type="checkbox"/> NOT APPROVED
	_____ REVIEWED BY
	____/____/____ *DATE RETURNED TO ENROLLING AGENCY