## Rhode Island EOHHS Drug Assistance Program RECERTIFICATION Enrollment Form

Do not write in this box $\rightarrow$	Insurance

## **Instructions:**

- You can enroll with a case manager at a RI Executive Office of Health & Human Services funded community-based organization to assist you with this application.
- Review RI EOHHS Drug Assistance Program Client Agreement Statement.
- Answer all of the questions on the *Financial Enrollment Form* (pages 1-3). Both you and your case manager (if you have one) must sign and date this form.
- Ask your medical doctor to complete and sign the *Medical Enrollment Form* (page 4).
- Submit both forms at the same time (*Financial and Medical*) along with proof of income and residency and copies of any health coverage/insurance cards.

residency and copies of any health coverage/insurance cards.				
Demographic Information  Last Name	First Name	МІ		
Street Address* (Mailing Address – Must be RI address)	City	Zip		
Is Mailing Address different than Residential Address? Yes No				
Do you want your confidential ADAP-Related mail to be sent to your mailing address? Yes No				
Telephone ( )	Social Security #			
Contacting You				
☐ Yes ☐ No Can we leave confidential message at this	phone number?			
☐ Yes ☐ No Would you prefer that future recertification	applications be sent to your case ma	anager?		
☐ Yes ☐ No Would you like to receive a text message?				
Date of Birth	Gender			
	☐ Male ☐ Female Transgender			
Sexual Orientation				
☐ Gay Man ☐ Lesbian ☐ Heterosexual ☐ Bisexua	al 🗆 Other			
Marital Status (Relationship Status)				
	☐ Divorced or Separated ☐			
*Remember to attach Proof of RI residency. This can include a copy of a driver's license, utility bill, or rental agreement. The address on the document should match the address above. If no permanent residence, your case manager can provide a letter documenting your current address.				
Case Manager				
Name	Organization			
Address	City, State, Zip			
Phone Fax ( )	E-Mail Address			
Case Manager's Signature				
Date:				
I DO NOT Have A Case Manager (please check if applicable)				

	Additional Comme	ents:		
		<b>npleted form by mail or fax to</b> ice of Health & Human Services		Tel: 401-462-3295
		3 West Road, Suite 227		Fax: 401-462-3297
	Cranston, RI	02920		
	http://www.eohh	s.ri.gov/	Page 1 of 4	Pov
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Financial Infor	mation			
Your househol	ld gross annual	Dependents (what is reported	Housing Status	
income*(what	is	on your tax return)		
reported on yo	our tax return)		☐ Permanent (rent or own)	
\$		(#)	☐ Temporary (shelter, family/friends, fac	ility)
Total Liquid As	ssets**(see defin	ition and exclusions below) \$		
Employment			☐ Homeless	
Employment				
Are you current	, , ,	□ Yes □ No		
*Gross household income means total income before taxes and deductions. Your household income includes all earnings and support, including SSDI, SSI, unemployment compensation, and other benefits, as well as, income from a legal spouse. Remember to attach proof of income, a copy of your most recent tax return for the most recent tax year, along with 2 most recent check stubs. If self-employed, include a copy of your most recent federal tax return or Mocked MAGI worksheet. If you have no earnings, please include a letter from your case manager stating that you have no income and describing how you are being supported. In addition to this letter, you will also need to complete a Mocked MAGI Worksheet.  **Liquid assets include any savings, checking, or money market accounts, stocks/bonds, investments, or other easily				
convertible assets EXCEPT for your primary residence and automobile.				
Insurance/Hea	Ith Care Coverag	je		
		or qualify for any of the follow o, indicate if you have applied	ving programs. If yes, provide you	r ID or Card # and/or
name or msu	rei/carrier. II II	☐ Yes ☐ No	· · · · · ·	/oc. □ No
		ID/Card#	If no, have you applied? ☐ Y Date applied:	
Medicaid/Medi	cal Assistance			
		☐ Managed Care? ☐ HMO?	?	
Medicare		☐ Yes ☐ No ID/Card#	If no, have you applied? ☐ ` Date applied:	
		☐ Yes ☐ No	If no, have you applied? ☐ \	′es □ No
Medicare Part		ID/Card#	Date applied:	
(Pharmacy Bei	nent)	Plan Name:		, , , , , , , , , , , , , , , , , , ,
Rite Care		☐ Yes ☐ No ID/Card#	If no, have you applied? ☐ \ Date applied:	′es □ No 
GPA		☐ Yes ☐ No ID/Card#	If no, have you applied? ☐ \ Date applied:	
EOHHS Rhode Assisted Progr	lsland Federally	⊓ Yes □ No	Does your prescription benef	its require you to use
, iooisica i iogi	· «··· (···· Ab)	ID/Card#		Yes ☐ No Insurers
		Name:	Date Ended	

Private Insurance	☐ Yes ☐ No		Does your prescription benefits require you to use			
1 Tivate insurance	ID/Card#			nacy?   Yes   No Insurers		
	Name:		Date Ended			
	☐ Yes ☐ No		If no, have you applied? ☐ Yes ☐ No			
Veterans Administration	ID/Card#	ID/Card#		Date applied:		
(VA)			Date Ended	Date Ended		
	☐ Yes ☐ No		If no, have you applied? ☐ Yes ☐ No			
Other Public Assistance	ID/Card#		Date applied:			
(specify)			Date Ended			
Le ADDI heleje z vev with CODDA/	La alth Income a a may man at 2	□ Vaa	□ Na			
Is APRI helping you with COBRA/I	Health Insurance payments?	⊔ Yes	□ No			
*Remember to attach a d you participate. Insurar				EQUIRED for enrollment.		
Return this completed form by mail	or fax to:					
Executive Office of Health & Human So	an daga		Ta	J. 404 460 2205		
Virks Building 3 West Road, Suite 227				al: 401-462-3295 ax: 401-462-3297		
Cranston, RI 02920			http://www.eohhs.ri.gov/			
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Pharmacy*						
Store Name		Phone		Do not write in this space		
		( )		☐ Pharmacy contacted		
Address				□ Filaillacy contacted		
				Date:		
				Date:		
*Pharmacy information is RE	QUIRED.					
Would you be interested in particing	pating in a Survey for EOHHS $\Box$	Yes □ N	No Focus Group fo	r EOHHS? 🗆 Yes 🗆 No		
Would you be interested in participut If yes, which is the best way to compare the compared to						
If yes, which is the best way to o						

I fully understand that by applying for this program, I am divulging personal information that will be used to assist The Executive Office of Health & Human Services in providing me with benefits associated with The RI Drug Assistance Program. I understand this information will be kept confidential, (§23-6-17 Confidentiality, §23-6-18 Protection of Records) but will be used by staff to review my eligibility for this program. Also, by signing this form, I understand that the information contained within may be used to verify HIV status, receive information from my physician about my care, or obtain other necessary information to provide me with these benefits. By applying for this program, I fully understand that this does not mean that my application will be accepted, as funds are limited, and eligibility requirements must be met. In addition, I understand The Executive Office of Health & Human Services reserves the right to terminate benefits due to non-adherence to medication pick up, not recertifying every 6 months, a lack of funds and/or fraudulent claims on behalf of an applicant. I also understand that this program is a payer of last resort, meaning that I must exhaust all other possible sources of payment for these services before applying for this program. Lastly, I understand that it is my responsibility to provide The Executive Office of Health & Human Services with truthful information and documentation about my financial, employment, insurance, and HIV status. I certify that the information provided in this application is true and correct as of the date below and acknowledge that any intentional or negligent misrepresentation of the information may result in nullification of this application and liability for money

granted.

- 1. It is my responsibility to re-apply (recertify) every 6 months on or before my birth month and 6 months following. If I do not recertify, my Drug Assistance benefits will be terminated.
- 2. It is my responsibility to pick up medications prescribed to me. I understand if I do not adhere to medication(s) prescribed, my Drug Assistance benefits will be terminated.

Lastly, I certify that I have received and agree to all the terms in The EC	OHHS RI Drug Assistance Program Client Agreement		
Statement.	<b>-</b> .		
Signature	Date		
Print Name			
Checklist			
Please submit all required forms and documents at one time vi page. Incomplete applications will delay your enrollment and a			
Did you remember to:			
☐ Attach proof of Rhode Island residency (copy of lease, utility bill with address, driver's license, etc.)?			
☐ Attach proof of income (e.g., copy most recent tax return along with 2 most recent pay stubs or Mocked MAGI			
worksheet)?			
☐ Include a completed Medical Enrollment Form (next pag	e) signed by your provider/physician?		
☐ Attach copy (-ies) of any health insurance or benefits cards?			
☐ Include your case manager's signature on page 1?			
☐ Sign the client agreement above?			
Return this completed form by mail or fax to:			
Executive Office of Health & Human Services	Tel: 401-462-3295		
Virks Building 3 West Road, Suite 227	Fax: 401-462-3297		
Cranston, RI 02920	http://www.eohhs.ri.gov/		
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Rhode Island EOHHS Drug Assistance Program MEDICAL Enrollment Form			
	Client Code		
Do not write in this box $ ightarrow$			

## This form is to be completed by the client's Medical Provider. Please print clearly and provide all requested information. Sign form and return to client. Client – Return this form together with the Financial Enrollment Form and all required documentation. **Client Name** Date of Birth day vear First MI Last **Date** HIV Approximate date of first positive HIV test: month day year **AIDS Diagnosis Date** ☐ Yes ☐ No If yes, date of diagnosis: month **HCV Test HCV** Diagnosis (if tested) **Date** □ Negative □ Positive If yes, date of test: □ Yes □ No month year General HIV Medical Care Visit Previous 6 **Date of Last General HIV Medical Care Visit months** ☐ Yes ☐ No Date of last test: (please provide date for both Yes or No response month day year CD4 Count **Date of Last CD4 Test** NADIR Count **Date of NADIR** Count: Count: month month day year day year **Most Recent Viral Load Date of Last Viral Load Test** Load: month day year Test Type: (bDNA,RT-PCR) Drug Therapy: Have you ordered medications on the ADAP formulary for this client? ☐ Yes ☐ No If Yes, which medication(s) were prescrtibed: Has the patient committed his/herself to take medication(s)? ☐ Yes ☐ No □ No HAART medications □ \_\_\_\_\_ (#) Antiretrovirals ☐ HCV Therapy Name of Physician (print)\_\_\_\_\_\_ RI Lic.#\_\_\_\_\_ Clinic Name: Signature of Physician\_\_\_\_\_ Date / / Return this completed form by mail or fax to: Executive Office of Health & Human Services Tel: 401-462-3295 Virks Building 3 West Road, Suite 227 Fax: 401-462-3297 Cranston, RI 02920 http://www.eohhs.ri.gov/

Instructions

## Rhode Island EOHHS Drug Assistance Program Client Agreement Statement

The following are guidelines that must be followed for you to receive drug coverage through the Rhode Island EOHHS Drug Assistance Program. The RI EOHHS Drug Assistance Program will keep your information strictly confidential §23 -6-17 Confidentiality, §23-6-18 Protection of Records). If you do not follow these guidelines, if you provide false information or withhold financial or other critical information or if we suspect you are using funds for the RI EOHHS Drug Assistance Program to which you are not entitled, you may be prosecuted, fined and/or terminated from RI EOHHS Drug Assistance Program.

By participating in the RI EOHHS Drug Assistance Program, I agree to the following:

- 1. I give permission to the RI EOHHS Drug Assistance Program staff (coordinator, program manager, administrator, eligibility technician) to contact:
  - a. My pharmacist
  - b. My case manager
  - c. My employer (for employee contributions to COBRA)
  - d. My current or past health care provider(s)
  - e. Any other person that I have specifically given permission to contact.

If needed, RI EOHHS Drug Assistance Program may contact these people to maintain my participation in the program. RI EOHHS Drug Assistance Program staff may also contact any insurance companies (third party payers/administrators) to make sure I am covered and to answer any billing questions. RI EOHHS Drug Assistance Program may also contact any of the people in the above list when I leave the program, if necessary. This may be done to get information about my participation in the program.

- 2. I give permission for my enrollment application files to be reviewed by the following: a. EOHHS staff
  - b. My case manager and/or health care provider
  - c. Auditors or other individuals reviewing application files as required for program fiscal monitoring. Information in your RI EOHHS Drug Assistance Program enrollment application files will be kept strictly confidential. Under no circumstances will any personal identifying information in my file be shared with any unauthorized individual.
- 3. I agree to notify RI EOHHS as soon as possible if any of this information changes. I need to report any other information that might change my eligibility for programs, including but not limited to a. Employment status
  - b. Income
  - c. Residence and Mailing address if separate
  - d. Access to insurance coverage/Medicaid status
  - e. Citizenship status
- 4. My application may be rejected if I have provided false information.
- 5. RI EOHHS cannot provide payments or reimbursements directly to me for any reason.
- 6. I may be required to pay back any RI EOHHS Drug Assistance Program benefits received if I was not eligible for them.
- 7. RI EOHHS is not required to make retroactive payments for coverage before I was enrolled in the program or if my enrollment lapses.
- 8. It is my responsibility to re-apply (recertify) with the Drug Assistance Program <u>every 6 months on or before my birth month and 6 months following.</u> If I do not recertify, my drug assistance benefits will be terminated.
- 9. It is my responsibility to pick up medications prescribed to me. I understand if I do not adhere to medication(s) prescribed, my drug assistance benefits will be terminated.
- 10. The enrolled client in the RI ADAP and or RIFAB programs assume full responsibility for accurate statements and reliable backup documents. Any person who knowingly and with intent to deceive the RIADAP and/or the RIFAB by providing containing any materially false information (e.g., Financial

forms, proof of residency, etc) or conceals for the purpose of misleading, information concerning a fact material thereto, and any person who in connection with such application or claim, who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report associated with this application/ recertification shall also be subject to a civil penalty.				