RYAN WHITE PART B/HIV MEDICATION ASSISTANCE PROGRAM FINANCIAL ELIGIBILITY AND AUTHORIZATION REQUEST

MAIL TO: NC Department of Health and Human Services, Division of Public Health
Purchase of Medical Care Services
1907 Mail Service Center
Raleigh, NC 27699-1907

This form is used to request authorization for the HMAP program and to collect financial information required for determination of HMAP eligibility. Once determined, eligibility extends for up to nine months. **A new form is required when changes in household and/or income occur**. Processing time is reduced when this form is legible. **Please print clearly**. **REMEMBER TO INCLUDE ALL REQUIRED DOCUMENTS.**

Submission of an incomplete application or failure to submit required income documentation will result in your application being delayed and could result in your application being denied. If approved, federal legislation requires NC HMAP to review client eligibility twice a year.

Section 1: Application Type

CASE NUMBER/Applicant Name: _____

Select Only **ONE**

☐ 1. Emergency/Expedited (Immediate Coverage*)

*If emergency coverage is requested, provide all required documentation. ***SEE THE HMAP MANUAL FOR MORE INFORMATION.***

☐ 2. New Application

Requested Delayed Start Date: ____/_____/20**_____Explanation:_____

If a delayed start date is requested, provide documentation and an explanation such as "private insurance ends at the end of the month," or "applicant will be released from prison on…" **SEE THE HMAP MANUAL FOR MORE INFORMATION.

☐ 3. Summer Renewal (October 1 to March 31)

☐ 4. Winter Renewal (April 1 to September 30)

☐ 5. Incarcerated **(Specify County Jail*****_____)

***If the applicant is incarcerated, provide the jail's address in Section 3. **Applicants incarcerated in state or federal prisons are not eligible for HMAP**.

Section 2: HMAP Sub-Program

*Indicate the sub-program that existing clients are served by or choose a sub-program for new applicants based on insurance status. Select Only **ONE:***

☐ 1. UMAP (No Insurance/Underinsured) ☐ 2. SPAP (Medicare D)

☐ 3. ICAP (Qualified Health Plan (Marketplace) COPAY ONLY) ☐ 4. PCAP (Marketplace Insurance PREMIUM and COPAY)

Section 3: Applicant Information

Last Name	First Name	MI

Date of Birth (MM/DD/YYYY)	Social Security Number ☐ I don't have a SSN

What is your current housing status?

☐ 1. Stable/Permanent ☐ 2. Temporary (staying with friend, hotel, college dorm) ☐ 3. Unstable (homeless and/or live in a shelter)

Residential/Home Address (**Must match documentation of residence)**	Apartment/Unit #

City	State **NC**	Zip Code	County	County Code

Telephone Number (Include Area Code)

Home: ( ) Cell: ( ) Work: ( )

Do you want mail sent to your residential address? ☐ 1. Yes ☐ 2. No. **Fill in preferred mailing address below.**

Mailing Address: _____City:_____ State:_____ Zip Code: _____

DHHS 3014/3056-HMAP (7/2018)
Questions? Please call 1-877-466-2232

Section 4: Applicant Demographics **CASE NUMBER/Applicant Name:** _____

Race

☐ 1. White ☐ 2. Black/African American ☐ 3. American Indian or Alaskan Native

☐ 4. Asian: (**Select Subcategory**)

☐ 1. Asian Indian ☐ 2. Chinese ☐ 3. Filipino ☐ 4. Japanese ☐ 5. Korean ☐ 6. Vietnamese ☐ 7. Other Asian

☐ 5. Native Hawaiian/Pacific Islander: (**Select Subcategory**)

☐ 1. Native Hawaiian ☐ 2. Guamanian or Chamorro ☐ 3. Samoan ☐ 4. Other Pacific Islander

☐ 6. Unknown

☐ 7. More Than One Race

Ethnicity

☐ 1. Hispanic/Latino(a):

☐ 1. Mexican/Mexican American ☐ 2. Puerto Rican ☐ 3. Cuban ☐ 4. Other Hispanic, Latino/a or Spanish Origin

☐ 2. Non-Hispanic

Preferred Language

☐ 1. English ☐ 2. Spanish ☐ 3. Other (Specify)_____

Current Gender

☐ 1. Male ☐ 2. Female ☐ 3. Transgender (Male to Female) ☐ 4. Transgender (Female to Male) ☐ 5. Transgender (Unknown)

Section 5: Applicant Health Information

HIV/AIDS Status

☐ 1. HIV Positive-Not AIDS

☐ 2. HIV Positive-CDC defined AIDS

☐ 3. HIV Positive-Status Unknown

First HIV/AIDS Diagnosis Date, if known

1. Month (MM)_____

2. Year (YYYY) _____

☐ 3. Date Unknown

Has the applicant received a current diagnosis* for Hepatitis C?

☐ 1. Yes

☐ 2. No

A current diagnosis is defined as 'actively infected', with a detectable hepatitis C viral load. Patients who have prior diagnoses that have cleared naturally or were treated and reached cure (SVR12), should check "NO".

Has the applicant used tobacco products four or more times per week in the past six months?

☐ 1. Yes

☐ 2. No

Section 6: Household Information

What is your tax filing status?

☐ Single

☐ Married, filing jointly

☐ Married, filing separately

☐ Head of Household

☐ Someone else claims me as a dependent on their tax return. **Specify**: _____

☐ I did not file taxes

What is your current employment status? Select Only **ONE:**

☐ Employed-Full Time

☐ Employed-Part time

☐ Employed- Seasonal/Temporary

☐ Retired

☐ Unemployed

☐ Medically Unable to Work

Section 7: Household Income Information **CASE NUMBER/Applicant Name:** _____

List the members of applicant household (**including applicant**) below:

Follow these rules for household.

- If **you file taxes**, your household members are you, your spouse and anyone you claim as a dependent on your tax return.
- If you do **NOT file taxes** and **NO ONE CLAIMS YOU** as a dependent on their tax return, your household members are your spouse and your natural /legal/adopted children or stepchildren living in the same house as you.

Full Name	Relationship to you	Does this person receive income?
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

Check each type of **INCOME** that you and others in your **household** receive and any **DEDUCTIONS** claimed on a tax return. **DOCUMENTATION OF EACH TYPE OF INCOME RECEIVED OR DEDUCTIONS CLAIMED BY YOUR HOUSEHOLD MUST BE SUBMITTED WITH YOUR APPICATION**. For acceptable forms of documentation, please refer to the HMAP Program Manual. **If household has NO INCOME, complete a Low/No Income Worksheet.**

Income Source	I receive this.	Someone in my household receives this.
NO HOUSEHOLD INCOME/DEDUCTIONS of any kind	☐	☐
Salary/Wages	☐	☐
Self-Employment Income	☐	☐
Any foreign earnings	☐	☐
Any non-taxable interest	☐	☐
Unemployment benefits	☐	☐
Pensions	☐	☐
Social Security (Retirement/Survivor's/Disability)	☐	☐
Retirement accounts	☐	☐
Alimony received	☐	☐
Net farming/fishing	☐	☐
Net rental/royalty	☐	☐
Net capital gain	☐	☐
Scholarships/Grants	☐	☐
Supplemental Security Income, Child Support, Veterans' Payments, or TANF/SNAP	☐	☐
Other Income (specify type):	☐	☐
Other Income (specify type):	☐	☐
DEDUCTION: Student loan interest paid	☐	☐
DEDUCTION: Alimony paid	☐	☐
Other Deduction (specify type):	☐	☐
TOTAL ANNUAL HOUSEHOLD INCOME (NC HMAP STAFF ONLY)	$	

Section 8: Assistance Information **CASE NUMBER/Applicant Name** _____

If applicant answered, "NO INCOME/DEDUCTIONS of any kind" above, please explain how the applicant is meeting basic needs. "The No/Low Income Sheet" should reflect what is checked in this box. **CHECK ALL THAT APPLY**

☐ Community Support
☐ Family Support
☐ Other, specify: _____

☐ Food Stamps/EBT
☐ Housing Assistance
☐ Medical Assistance
☐ Utility Assistance
☐ Transportation Assistance

☐ Migrant Worker
☐ Unemployment Benefits
From: ____/_____/**20**___
To: _____/_____/**20**____

Medicare, Medicaid and, if applicable, Social Security eligibility information for a low-income subsidy are required for all applicants. If applicant selects "SS LIS Application", the date must be included. **CHECK ALL THAT APPLY**

Has the applicant applied for any of the following benefits in the past 6 months?

☐ Medicaid
☐ Medicare
☐ Medicare Part D (**complete Section 9**)
☐ SS LIS Application
specify date: _____/_____/**20**____
☐Other, specify: _____

Section 9: Medicare Insurance Policy Information

If the applicant has a Medicare Part D plan, please provide information from the applicant's Part D card and provide a **copy of the card**.

☐ Not Applicable

Medicare Part D Company and Plan Name

Medicare Member ID/Policy #	Policy Holder

RX BIN	RX PCN	RX Group

Section 10: Qualified Health Insurance Information

What type of QHP Insurance assistance are you requesting from NC HMAP for this health policy?

☐ Medication Co-Pay ONLY (*ICAP*) **FILL OUT SECTION 10 ONLY**, provide a copy of most recent insurance card.

☐ Medication Co-Pay AND Health Insurance Premiums (*PCAP*) **FILL OUT SECTION 10 and 11**, provide documentation.

Health Insurance Company & Plan Name

Health Insurance Member ID/Policy #	Policy Holder

RX BIN	RX PCN	RX Group

Is patient covered?	Does insurance have a cap?
☐ 1. Yes ☐ 2. No	☐ 1. Yes ☐ 2. No If yes please provide amount and submit documentation $_____

Section 11: Qualified Health Insurance PREMIUM Information **CASE NUMBER/Applicant Name:** _____

REQUIRED DOCUMENTS: If you're requesting assistance AND (a) you're a new NC HMAP client, or (b) you're already a NC HMAP client and this is a new plan/the first time you are asking for premium assistance with this plan, you must include a copy of your premium invoice and proof the advance premium tax credit was applied in full via the Marketplace. If you receive any refund or money from the IRS, insurance company or another source because your premium was overpaid, you MUST return that refund to NC HMAP.

What is your portion of the primary health premium amount? $	Next Payment Due Date / /
Is this a medical plan only? ☐ 1. Yes ☐ 2. No. **NC HMAP can only pay for MEDICAL insurance plans.**	Is this an Individual health plan? ☐1. Yes ☐ 2. No (*see NC HMAP Program Manual for further instruction.*)

Do you have any premium payments that are past due? ☐ 1.Yes **PAST DUE BALANCES MUST BE PAID BEFORE NC HMAP CAN ASSIST WITH INSURANCE PREMIUM PAYMENTS**. ☐ 2. No

Is your premium payment account set up for automatic payment? ☐1. Yes **PLEASE REMOVE PRIOR TO PROGRAM APPROVAL.** ☐ 2. No

Section 12: Terms and Conditions for Applicant

I agree to notify the interviewer within 30 days about any changes in my address, financial resources, expenses, family situation, or health insurance coverage that might affect my eligibility for Department payment programs. I certify that the information I have provided is a true and complete statement of facts according to my best knowledge and belief. I understand that information provided may be checked by a state reviewer, and I agree to provide the financial records required to carry out this investigation. I also understand that my employer may be asked to verify information concerning my income.

I assign insurance benefits to the Department. I agree to repay the Department any money I receive from insurance or liability settlements for services or appliances which the Department purchased for me. I understand that such payments should be made to the Department within 45 days of the date that I receive them and that the amount paid to the Department should not exceed the amount the Department paid the provider. I further agree that failure to repay assigned insurance benefits to the Department is a reason for denial of future service requests to the Department until such amounts have been repaid.

I understand that my eligibility for Medicaid will be checked. I hereby authorize and agree to a free exchange of information between the Division of Medical Assistance and the Department of Health and Human Services relating to financial information and the amount of services provided by either program.

I hereby authorize the interviewer and service providers to release to the Department and its affiliate programs the information provided on this form and also the medical records of the patient which pertain to medical services or appliances for which reimbursement is being sought from the Department.

I also authorize release of this information to the county health department where the patient resides and/or receives services. I also authorize release of the information on this form to all health departments, hospitals, and service providers in North Carolina. These disclosures shall be made for purposes of determining the patient's eligibility for Department payment programs and for conducting program evaluation.

I also authorize release of enrollment, eligibility and utilization records to my physicians, my case manager, other medical providers, the contracted pharmacy, Pharmacy Benefits Managers, third party administrators, health insurers or other service providers to facilitate program services.

I voluntarily give my consent to the terms of this release. My consent shall be valid for a period of one year. I further understand that I may revoke my consent at any time. Such revocation does not affect the validity of my consent for information disclosed prior to the revocation.

I understand that I may appeal the denial of this financial eligibility application. Information on how to appeal the denial can be obtained by writing to Purchase of Medical Care Services, 1907 Mail Service Center, Raleigh NC 27699-1907. I understand that payment by the Department for health care provided to me is dependent upon me meeting all financial and medical requirements, timely submission of authorization requests and claims, and the availability of funds.

SECTION 13: Signatures **CASE NUMBER/Applicant Name:**_____

I hereby certify that I have read or the interviewer has read to me the terms and conditions described within and that I agree to comply with them. I also certify that I have been provided an opportunity to ask the interviewer questions about these terms and conditions and that I understand the answers I was given.

Applicant's Signature | Relationship to Applicant | Current Date (MM/DD/YYYY)

_____ _____ _____

I certify that I have explained the terms and conditions contained within and have witnessed his/her signature.

Interviewer's Signature | Current Date(MM/DD/YYYY)

_____ _____

Interviewer's Name: _____

Agency: _____

Agency Address: _____

City: _____ County Code: _____ State: _____ Zip Code: _____

Phone number: (_____)_____

Alternate Interviewer Contact (if applicable): _____

Phone number: (_____)_____

I certify that the above-named individual is HIV positive and has prescriptions for medication listed on the current NC HMAP Formulary.

Clinician's Signature | Current Date(MM/DD/YYYY)

_____ _____

Clinician's Name	Clinician's NC License #:

Agency: _____

Agency Address: _____

City: _____ County Code: _____ State: _____ Zip Code: _____

Phone number: (_____)_____

North Carolina County Codes				
001 ALAMANCE	021 CHOWAN	041 GUILFORD	061 MITCHELL	081 RUTHERFORD
002 ALEXANDER	022 CLAY	042 HALIFAX	062 MONTGOMEY	082 SAMPSON
003 ALLEGHANY	023 CLEVELAND	043 HARNETT	063 MOORE	083 SCOTLAND
004 ANSON	024 COLUMBUS	044 HAYWOOD	064 NASH	084 STANLY
005 ASHE	025 CRAVEN	045 HENDERSON	065 NEW HANOVER	085 STOKES
006 AVERY	026 CUMBERLAND	046 HERTFORD	066 NORTHAMPTON	086 SURRY
007 BEAUFORT	027 CURRITUCK	047 HOKE	067 ONSLOW	087 SWAIN
008 BERTIE	028 DARE	048 HYDE	068 ORANGE	088 TRANSYLVANIA
009 BLADEN	029 DAVIDSON	049 IREDELL	069 PAMLICO	089 TYRRELL
010 BRUNSWICK	030 DAVIE	050 JACKSON	070 PASQUOTANK	090 UNION
011 BUNCOMBE	031 DUPLIN	051 JOHNSTON	071 PENDER	091 VANCE
012 BURKE	032 DURHAM	052 JONES	072 PERQUIMANS	092 WAKE
013 CABARRUS	033 EDGECOMBE	053 LEE	073 PERSON	093 WARREN
014 CALDWELL	034 FORSYTH	054 LENOIR	074 PITT	094 WASHINGTON
015 CAMDEN	035 FRANKLIN	055 LINCOLN	075 POLK	095 WATAUGA
016 CARTERET	036 GASTON	056 MACON	076 RANDOLPH	096 WAYNE
017 CASWELL	037 GATES	057 MADISON	077 RICHMOND	097 WILKES
018 CATAWBA	038 GRAHAM	058 MARTIN	078 ROBESON	098 WILSON
019 CHATHAM	039 GRANVILLE	059 MCDOWELL	079 ROCKINGHAM	099 YADKIN
020 CHEROKEE	040 GREENE	060 MECKLENBURG	080 ROWAN	100 YANCEY

* Interviewers and clinicians located outside of North Carolina should use County Code 000 .