Rhode Island EOHHS Drug Assistance Program
Enrollment Form

Do not write in this box →		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. If there are any questions, please call **401-462-3294 or 401-462-3295**

Demographic Information

Last Name	**First Name**	**MI**
Street Address* (Mailing Address - *Must be RI address)*	**City**	**Zip**
Mailing address (if it differs from Street Address)	**City**	**Zip**
Contact information: Home ( ) - Cell ( ) -	**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 manager?

Date of Birth _____/_____/_____	**Gender** ☐ Male ☐ Female ☐ Transgender

Sexual Orientation

☐ Gay Man ☐ Lesbian ☐ Heterosexual ☐ Bisexual ☐ Other

Marital Status (Relationship Status)

☐ Married ☐ Domestic Partner ☐ Single/Never Married ☐ Divorced or Separated ☐ Widowed

Ethnicity (please check one)	**Race**
☐ Hispanic/Latino(a)	☐ White ☐ Native Hawaiian/Pacific Islander
☐ Not Hispanic/Latino(a)	☐ Black ☐ American Indian/Alaska Native
Please also complete race→	☐ Asian ☐ More than one race
Country of Birth	**Preferred Spoken Language**

HIV Transmission

How did you contract HIV? ☐ Male to male sex ☐ Heterosexual sex ☐ Other ☐ IV drug use ☐ Do not know

***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 MANANGER (please check if applicable)**

Additional Comment:

Return this completed form by email to both: Denise.cappelli@ohhs.ri.gov & Lyubov.adamova@ohhs.ri.gov
Mail to: : Executive Office of Health & Human Services ⬬ Virks Building, Suite 227 ⬬ 3 West Rd., Cranston, RI. 02920 ⬬
Fax: 401-462-3297

Rev. 11/25/2020

Financial Information

Your household gross annual income*(what is reported on your tax return) $_____	Dependents (what is reported on your tax return) _____(#)	Housing Status ☐ Permanent (rent or own) ☐ Temporary (shelter, family/friends, facility) ☐ Homeless
Total Liquid Assets**(see definition and exclusions below) $		

Employment

Are you currently employed? ☐ 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, such as a copy of your most recent tax return for the most recent tax year. 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/Health Care Coverage

Please indicate whether your health care is paid for by any of the following programs. If yes, provide your ID or Card # and/or name of insurer/carrier. If no, indicate if you have applied and when (if applicable).

Medicaid/Medical Assistance	☐ Yes ☐ No ID/Card#_____ ☐ Managed Care? ☐ HMO?	If no, have you applied? ☐ Yes ☐ No Date applied:_____
Medicare	☐ Yes ☐ No ID/Card#_____	If no, have you applied? ☐ Yes ☐ No Date applied:_____
Medicare Part D (Pharmacy Benefit)	☐ Yes ☐ No ID/Card#_____ Plan Name:	If no, have you applied? ☐ Yes ☐ No Date applied:_____
Rite Care	☐ Yes ☐ No ID/Card#_____	If no, have you applied? ☐ Yes ☐ No Date applied:_____
GPA	☐ Yes ☐ No ID/Card#_____	If no, have you applied? ☐ Yes ☐ No Date applied:_____
Private Insurance (including QHP clients receiving Premium Assistance through EOHHS-RIFAB)	☐ Yes ☐ No ID/Card#_____ Insurers Name:	Does your prescription benefits require you to use a mail order pharmacy? ☐ Yes ☐ No
Veterans Administration (VA)	☐ Yes ☐ No ID/Card#_____	If no, have you applied? ☐ Yes ☐ No Date applied:_____
Other Public Assistance (specify)_____	☐ Yes ☐ No ID/Card#_____	If no, have you applied? ☐ Yes ☐ No Date applied:_____
Insurance coverage that has terminated in the last 12 months? * (if applicable)	No ID/Card#_____ insurers Name: _____	Active date:_____ Termination date:_____

Is AIDS Project RI helping you with COBRA/Health Insurance payments? ☐ Yes ☐ No

***Remember to attach a copy of your insurance card for any of the programs above in which you participate. Insurance information and a copy of your card are REQUIRED for enrollment.**

Return this completed form by email to both: Denise.cappelli@ohhs.ri.gov & Lyubov.adamova@ohhs.ri.gov
Mail to: : Executive Office of Health & Human Services ⬬ Virks Building, Suite 227 ⬬ 3 West Rd., Cranston, RI. 02920 ⬬
Fax to: 401-462-3297

Pharmacy*		
Store Name	**Phone** ( ) _____-_____	**Do not write in this space** ☐ Pharmacy contacted Date:_____
Address		

***Pharmacy information is REQUIRED. Without it, we cannot contact the pharmacy and enroll you in the program.**

Would you be interested in participating in a Survey for ADAP ☐ Yes ☐ No Focus Group for ADAP? ☐ Yes ☐ No
If yes, which is the best way to contact you? (by phone please list phone number, by email please list email address)
Phone_____email_____

Client Certification and Signature

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) with ADAP 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 EOHHS RI Drug Assistance Program Client Agreement Statement.**

Signature_____ Date_____

Print Name_____

Checklist

Please submit all required forms and documents at one time via fax or mail to the address at the bottom of the page. Incomplete applications will delay your enrollment and access to this program.

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 or Mocked MAGI worksheet)?
- ☐ Include a completed Medical Enrollment Form (next page) 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 email to both: Denise.cappelli@ohhs.ri.gov **&** Lyubov.adamova@ohhs.ri.gov
Mail to: Executive Office of Health & Human Services ● Virks Building, Suite 227 ● 3 West Rd., Cranston, RI. 02920 ●
Fax to: 401-462-3297

Rhode Island AIDS Drug Assistance Program
MEDICAL Enrollment Form

Do not write in this box →	**Client Code**

Instructions

- **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

Last First MI

Date of Birth

_____/_____/_____

month day year

HIV

Approximate date of first positive HIV test:

Date

_____/_____/_____

month day year

AIDS Diagnosis

□ Yes □ No If yes, date of diagnosis:

Date

_____/_____/_____

month day year

HCV Test

□ Yes □ No If yes, date of test:

Date

_____/_____/_____

month day year

HCV Diagnosis (if tested)

□ Negative □ Positive

General HIV Medical Care Visit Previous 6 months

□ Yes □ No

(please provide date for both Yes or No response)

Date of Last General HIV Medical Care Visit

Date of last test: _____/_____/_____

month day year

CD4 Count

Count:_____

Date of Last CD4 Test

_____/_____/_____

Month day year

NADIR Count

Count:_____

Date of NADIR

_____/_____/_____

Viral Load (Most Recent)

Load:_____

Date of Last Viral Load Test

_____/_____/_____

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 prescribed:_____

Has the patient committed his/her self 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 email to both: Denise.cappelli@ohhs.ri.gov & Lyubov.adamova@ohhs.ri.gov
Mail to: Executive Office of Health & Human Services ● Virks Building, Suite 227 ● 3 West Rd., Cranston, RI. 02920●
Fax to: 401-462-3297

Rev. 11/25/2020

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 if we suspect you are using funds for the RI EOHHS Drug Assistance Program to which you are not entitled, you may be 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, eligibility technician, administrator) 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.