

OA-PCIP

Enrollment Worker Training



CA Department of Public Health
Office of AIDS (OA)
Insurance Assistance Section

Managed Risk Medical Insurance Board
(MRMIB)



Managed Risk Medical Insurance Board



Learning Objectives

- **By the end of this course you will...**
 - ...know the basics of OA-PCIP
 - ...understand the eligibility criteria
 - ...be able to complete the appropriate forms
 - ...be certified as an OA-PCIP Enrollment Worker
 - ...be a PCIP Certified Application Assistant





Our Path Today

1. What is OA-PCIP?
2. Eligibility/Certification
3. Application Process
4. Enrollment





PCIP v OA-PCIP

PCIP -



- Federally funded program that offers health insurance coverage to uninsured CA residents who have a pre-existing condition
- Administered by the Managed Risk Medical Insurance Board (MRMIB)



Managed Risk Medical Insurance Board

OA-PCIP

- A subsidy program that pays monthly health insurance premiums to MRMIB for eligible clients.





PCIP & OA-PCIP cont...

- PCIP Application and
- OA-PCIP Application
- Both must be submitted to OA!





OA-PCIP

Eligibility Requirements

- Client must meet *all* PCIP *and* OA-PCIP requirements





PCIP Requirements

- Must be a US Citizen, US national or lawfully present individual
- Must be a California resident
- Must have a pre-existing condition
- Must be without health insurance for at least the past six months
 - Ryan White services are *not* considered health insurance
 - LIHP/CMSP are considered health insurance





OA-PCIP Requirements

- Must be enrolled in PCIP
- Must be 18-64 years old
- Must have an HIV or AIDS diagnosis
- Must have an adjusted gross income that does not exceed \$50,000





OA-PCIP Clients

- Can also have their co-pays and deductibles for HIV-related medications paid for if they are also enrolled in ADAP.
- The money ADAP pays for the co-pays and deductibles will count towards the clients out-of-pocket maximum
 - Clients must visit a CVS Pharmacy to receive this benefit.



Questions





Our Path Today

1. OA-PCIP
2. Eligibility/Certification
3. Application Process
4. Enrollment





Application Packet

- All forms in the OA-PCIP Application Packet are the *same* as OA-HIPP except for the:
 1. OA-PCIP Checklist
 2. OA-PCIP Program Application
- Supplemental documentation requirements are the same for OA-PCIP and OA-HIPP



Checklist

- Provides a summary of all program documentation requirements. 




OA-PCIP CHECKLIST

The Office of AIDS Pre-Existing Insurance Plan (OA-PCIP) will pay PCIP health insurance premiums for individuals that meet the following requirements:

- Must be a California resident;
- Must be a U.S. Citizen, U.S. National, or lawfully present individual;
- Must be without health insurance coverage for the past six months, including an individual or job based health plan, COBRA, Cal-COBRA, Medicare Part A, and/or Part B, Medi-Cal, or CMSP
- Must be between the ages of 18 and 64
- Must have an HIV/AIDS diagnosis; and
- Must have an income not to exceed \$50,000

If you meet the program requirements and would like to enroll in OA-PCIP, please complete the following forms that apply completely and accurately.

Is this the OA/HIPP annual enrollment or recertification?	Enroll	Recert	Enroll	Recert
1. OA-PCIP Application	x	x	x	x
ID Verification, submit a copy of one of the following: Driver's License, State ID, School ID, Military ID, Passport, Permanent Residence Card, Work Permit, or Birth Certificate (if no other form of photo ID).			x	
California Residency Verification, submit a copy of one of the following: Utility Bill (electricity, water, gas, cable), Lease Agreement, Rent Receipt, Mortgage Statement, Voter's Registration, Vehicle Registration, or Support Verification Affidavit			x	
HIV/AIDS Diagnosis Verification, must submit: Diagnosis Form (one time)	x		x	
Income Verification, submit the Financial Eligibility Form and the following income documentation that apply: California State tax Return, Federal Income Tax return, W-2 or 1099 tax form, Pay Stub*, Bank Statement** (must clearly state income source), Benefit Receipt* or Check Stub*, Disability Award letter, Support Verification Affidavit, or Self-Employment Affidavit. *3 current consecutive months			x	
Public Assistance Screening Form and supporting documentation			x	
2. Consent Form	x		x	
3. Client Report Form	x		x	
4. PCIP Enrollment Application	x		x	
Proof of citizenship or immigration status, submit a copy of one of the following Birth Certificate, Passport, Certificate of U.S. Citizenship or Naturalization, Other Proof of citizenship	x		x	

Applications will not be processed until all forms and documentation is provided.

Please mail the completed forms and supporting documentation to:

Insurance Assistance Section
California Department of Public Health
P.O. Box 997426, MS 7704
Sacramento, 95899-7426

Or fax to (916) 449-5860



Checklist

- Same as OA-HIPP Checklist, but also includes *PCIP* application




OA-PCIP CHECKLIST

The Office of AIDS Pre-Existing Insurance Plan (OA-PCIP) will pay PCIP health insurance premiums for individuals that meet the following requirements:

- Must be a California resident;
- Must be a U.S. Citizen, U.S. National, or lawfully present individual;
- Must be without health insurance coverage for the past six months, including an individual or job based health plan, COBRA, Cal-COBRA, Medicare Part A, and/or Part B, Medi-Cal, or CMSP
- Must be between the ages of 18 and 64
- Must have an HIV/AIDS diagnosis, and
- Must have an income not to exceed \$50,000

If you meet the program requirements and would like to enroll in OA-PCIP, please complete the following forms that apply completely and accurately.

Are you currently enrolled in ADAP?	With ADAP		Without ADAP	
	Enroll	Recert	Enroll	Recert
Is this the OA/HIPP annual enrollment or recertification?				
1. OA-PCIP Application	x	x	x	x
ID Verification - submit a copy of one of the following: Driver's License, State ID, School ID, Military ID, Passport, Permanent Residence Card, Work Permit, or Birth Certificate (if no other form of photo ID)			x	
California Residency Verification, submit a copy of one of the following: Utility Bill (electricity, water, gas, cable), Lease Agreement, Rent Receipt, Mortgage Statement, Voter's Registration, Vehicle Registration, or Support Verification Affidavit			x	
HIV/AIDS Diagnosis Verification, must submit: Diagnosis Form (one time)	x		x	
Income Verification, submit the Financial Eligibility Form and the following income documentation that apply: California State tax Return, Federal Income Tax return, W-2 or 1099 tax form, Pay Stub*, Bank Statement* (must clearly state income source), Benefit Receipt* or Check Stub*, Disability Award letter, Support Verification Affidavit, or Self-Employment Affidavit *3 current consecutive months			x	
Public Assistance Screening Form and supporting documentation			x	
2. Consent Form	x		x	
3. Client Report Form	x		x	
4. PCIP Enrollment Application	x		x	
Proof of citizenship or immigration status, submit a copy of one of the following Birth Certificate, Passport, Certificate of U.S. Citizenship or Naturalization, Other Proof of citizenship	x		x	

Applications will not be processed until all forms and documentation is provided.

Please mail the completed forms and supporting documentation to:

Insurance Assistance Section
California Department of Public Health
P.O. Box 997426, MS 7704
Sacramento, 95899-7426

Or fax to (916) 449-5860



Checklist

- Provides examples of types of supplemental documentation that can be submitted to fulfill program requirements.

1. OA-PCIP Application	x	x	x	x
ID Verification, submit a copy of one of the following: Driver's License, State ID, School ID, Military ID, Passport, Permanent Residence Card, Work Permit, or Birth Certificate (if no other form of photo ID)				
California Residency Verification, submit a copy of one of the following: Utility Bill (electricity, water, gas, cable), Lease Agreement, Rent Receipt, Mortgage Statement, Voter's Registration, Vehicle Registration, or Support Verification Affidavit			x	
HIV/AIDS Diagnosis Verification, must submit: Diagnosis Form (one time)	x		x	
Income Verification, submit the Financial Eligibility Form and the following income documentation that apply: California State tax Return, Federal Income Tax return, W-2 or 1099 tax form, Pay Stub*, Bank Statement* (must clearly state income source), Benefit Receipt* or Check Stub*, Disability Award letter, Support Verification Affidavit, or Self-Employment Affidavit *3 current consecutive months			x	
Public Assistance Screening Form and supporting documentation			x	
2. Consent Form	x		x	
3. Client Report Form	x		x	
4. PCIP Enrollment Application	x		x	





Checklist

- The Checklist is not meant to be all-inclusive, please refer to program guidelines.
- Other forms of documentation not listed may suffice to meet program requirements.



OA-PCIP CHECKLIST



The Office of AIDS Pre-Existing Insurance Plan (OA-PCIP) will pay PCIP health insurance premiums for individuals that meet the following requirements:

- Must be a California resident;
- Must be a U.S. Citizen, U.S. National, or lawfully present individual;
- Must be without health insurance coverage for the past six months, including an individual or job based health plan, COBRA, Cal-COBRA, Medicare Part A, and/or Part B, Medi-Cal, or CMSP
- Must be between the ages of 18 and 64
- Must have an HIV/AIDS diagnosis; and
- Must have an income not to exceed \$50,000

If you meet the program requirements and would like to enroll in OA-PCIP, please complete the following forms that apply completely and accurately.

Are you currently enrolled in ADAP?	With ADAP		Without ADAP	
	Enroll	Recert	Enroll	Recert
Is this the OA/HIPP annual enrollment or recertification?				
1. OA-PCIP Application	x	x	x	x
ID Verification, submit a copy of one of the following: Driver's License, State ID, School ID, Military ID, Passport, Permanent Residence Card, Work Permit, or Birth Certificate (if no other form of photo ID)			x	
California Residency Verification, submit a copy of one of the following: Utility Bill (electricity, water, gas, cable), Lease Agreement, Rent Receipt, Mortgage Statement, Voter's Registration, Vehicle Registration, or Support Verification Affidavit			x	
HIV/AIDS Diagnosis Verification, must submit: Diagnosis Form (one time)	x		x	
Income Verification, submit the Financial Eligibility Form and the following income documentation that apply: California State tax Return, Federal Income Tax return, W-2 or 1099 tax form, Pay Stub*, Bank Statement* (must clearly state income source), Benefit Receipt* or Check Stub*, Disability Award letter, Support Verification Affidavit, or Self-Employment Affidavit *3 current consecutive months			x	
Public Assistance Screening Form and supporting documentation			x	
2. Consent Form	x		x	
3. Client Report Form	x		x	
4. PCIP Enrollment Application	x		x	
Proof of citizenship or immigration status, submit a copy of one of the following Birth Certificate, Passport, Certificate of U.S. Citizenship or Naturalization, Other Proof of citizenship	x		x	

Applications will not be processed until all forms and documentation is provided.

Please mail the completed forms and supporting documentation to:

Insurance Assistance Section
California Department of Public Health
P.O. Box 997426, MS 7704
Sacramento, 95899-7426

Or fax to (916) 449-5860

Forms

1. Program Application
2. Diagnosis Form
3. Financial Eligibility Form
4. Support Verification Affidavit
5. Self-Employment Affidavit
6. Public Assistance Screening Form
7. Insurance Assistance Consent Form
8. Client Report Form





1. Program Application

OA-PCIP APPLICATION

Are you currently enrolled in the AIDS Drug Assistance Program (ADAP)? YES NO
 If Yes, ADAP Client ID Number: _____
 Did you know ADAP pays prescription deductibles and co-payments for drugs on the ADAP formulary?
 We encourage you to apply. For more information, call (888) 311-7632.

I. Applicant Information				
Applicant's Name (First, MI, Last)		Date of Birth (mm/dd/yyyy)		Mother's Maiden Name
Home Address (Number, Street, Apt #)	City	County	State	Zip Code
Mailing Address (if different than home)	City	County	State	Zip Code
Telephone Number (Home)		Telephone Number (Alternate)		
<p>IMPORTANT: Please note that the information on this form is being collected to determine eligibility for benefits under the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87) and is required by the California Department of Public Health (CDPH), Office of AIDS (OA). The information may be used to contact insurance companies, employers, providers of health care services, and state and county agencies to determine the extent of available health insurance and eligibility for insurance assistance. Failure to provide the mandatory information may result in the application not being processed. You have the right to review the information maintained by CDPH unless access is exempt by law. To access the information, contact CDPH Insurance Assistance Section, MS 7704, P.O. Box 997426, Sacramento, CA 95899-7426, or by phone at (800) 367-2437.</p> <p>AUTHORIZATION: I authorize insurance companies, employers, providers of health care services, and state and county agencies to release of information to the CDPH with regard to health insurance premiums and benefits. I authorize payment of refunds to CDPH for premiums paid by OA's Pre-Existing Condition Insurance Plan (OA-PCIP).</p> <p>DECLARATION: I agree to re-enroll annually and re-certify as required by the OA-PCIP Program. I agree to inform OA of any changes to my eligibility requirements for the program as soon as I am aware of these changes. I certify that the answers I have given in this application and the documents provided are true and correct to the best of my knowledge. I understand that failure to provide accurate information may result in termination of insurance premium assistance.</p>				
_____ Signature of Applicant		_____ Date		
STATE OF CALIFORNIA USE ONLY – AUTHORIZATION TO PAY PREMIUM				
Monthly premium Amount \$ _____	x Months _____ = Total Paid \$ _____	Effective Date _____ to _____	OA-PCIP Liaison _____	
The CDPH Insurance Assistance Section authorizes the above payment(s) in the amount indicated above to the California Major Risk Medical Insurance Program for PCIP premiums.				
_____ Authorized Signature		_____ Date		



1. Program Application

- Same as the OA-HIPP Program Application, except there is no section regarding current Health Plan data (PCIP clients are uninsured.)

State of California - Health and Human Services Agency California Department of Public Health

OA-PCIP APPLICATION

Are you currently enrolled in the AIDS Drug Assistance Program (ADAP)? YES NO
 If Yes, ADAP Client ID Number: _____
 Did you know ADAP pays prescription deductibles and co-payments for drugs on the ADAP formulary?
 We encourage you to apply. For more information, call (888) 311-7832.

I. Applicant Information

Applicant's Name (First, MI, Last)		Date of Birth (mm/dd/yyyy)		Mother's Maiden Name	
Home Address (Number, Street, Apt #)		City	County	State	Zip Code
Mailing Address (if different than home)		City	County	State	Zip Code
Telephone Number (Home)			Telephone Number (Alternate)		

IMPORTANT: Please note that the information on this form is being collected to determine eligibility for benefits under the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87) and is required by the California Department of Public Health (CDPH), Office of AIDS (OA). The information may be used to contact insurance companies, employers, providers of health care services, and state and county agencies to determine the extent of available health insurance and eligibility for insurance assistance. Failure to provide the mandatory information may result in the application not being processed. You have the right to review the information maintained by CDPH unless access is exempt by law. To access the information, contact CDPH Insurance Assistance Section, MS 7704, P.O. Box 997426, Sacramento, CA 95899-7426, or by phone at (800) 367-2437.

AUTHORIZATION: I authorize insurance companies, employers, providers of health care services, and state and county agencies to release of information to the CDPH with regard to health insurance premiums and benefits. I authorize payment of refunds to CDPH for premiums paid by OA's Pre-Existing Condition Insurance Plan (OA-PCIP).

DECLARATION: I agree to re-enroll annually and re-certify as required by the OA-PCIP Program. I agree to inform OA of any changes to my eligibility requirements for the program as soon as I am aware of these changes. I certify that the answers I have given in this application and the documents provided are true and correct to the best of my knowledge. I understand that failure to provide accurate information may result in termination of insurance premium assistance.

Signature of Applicant _____ Date _____

STATE OF CALIFORNIA USE ONLY – AUTHORIZATION TO PAY PREMIUM

Monthly premium Amount \$ _____ x Months _____ = Total Paid \$ _____	Effective Date _____ to _____	OA-PCIP Liaison _____
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The CDPH Insurance Assistance Section authorizes the above payment(s) in the amount indicated above to the California Major Risk Medical Insurance Program for PCIP premiums.

II. Current Plan Information (Please attach a copy of your member ID card and a billing statement)

Plan Name (See member ID card)	Member ID Number	Policy Number
Payee name	Premium Amount \$ _____ Monthly	Payee's Federal Tax ID Number
Payee Address (Number, Street or P.O. Box)	City	State Zip Code

IMPORTANT: Please note that the information on this form is in accordance with the Ryan White HIV/AIDS Treatment and



1. Program Application

Basic Client information

- Name, Address, etc.

State of California - Health and Human Services Agency California Department of Public Health

OA-PCIP APPLICATION

Are you currently enrolled in the AIDS Drug Assistance Program (ADAP)? YES NO
If Yes, ADAP Client ID Number: _____
Did you know ADAP pays prescription deductibles and co-payments for drugs on the ADAP formulary?
We encourage you to apply. For more information, call (888) 311-7632.

I. Applicant Information

Applicant's Name (First, MI, Last)		Date of Birth (mm/dd/yyyy) / /		Mother's Maiden Name	
Home Address (Number, Street, Apt #)		City	County	State	Zip Code
Mailing Address (if different than home)		City	County	State	Zip Code
Telephone Number (Home)			Telephone Number (Alternate)		



2. Diagnosis Form

State of California - Health and Human Services Agency

California Department of Public Health

DIAGNOSIS FORM INSURANCE ASSISTANCE SECTION

This form must be completed and signed by a Medical Doctor (M.D. or D.O.), Physician Assistant, or Nurse Practitioner who is licensed to practice.		
I. Patient Information		
Applicant's Name (First, MI, Last)		Date of Birth (mm/dd/yyyy)
Does this patient have HIV infection? <input type="checkbox"/> Yes <input type="checkbox"/> No		
II. Physician Information		
Physician Name:		
Address (Number, Street, Suite #)		City
		Zip Code
Telephone Number		Fax Number
<p>Please note that the information on this form is being collected to determine eligibility for benefits under the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87) and is required by the California Department of Public Health (CDPH), Office of AIDS. The information may be used to determine eligibility for insurance assistance. Failure to provide the mandatory information may result in the application not being processed. You have the right to review the information maintained by CDPH unless access is exempt by law. To access the information, contact CDPH Insurance Assistance Section, MS 7704, P.O. Box 997426, Sacramento, CA 95899-7426, or by phone at (800) 367-2437.</p>		
I certify that the information provided on this form is true and correct to the best of my knowledge.		
_____		_____
Licensed Health Care Provider Name (Printed)		License Number
_____		_____
Licensed Health Care Provider (Signature)		Date Signed



2. Diagnosis Form

- Used to verify HIV/AIDS diagnosis
- Must be submitted for all clients
- Must be signed by a doctor, physician assistant or nurse practitioner

This form must be completed and signed by a Medical Doctor (M.D. or D.O.), Physician Assistant, or Nurse Practitioner who is licensed to practice.

I. Patient Information		
Applicant's Name (First, MI, Last)	Date of Birth (mm/dd/yyyy)	
Does this patient have HIV infection? <input type="checkbox"/> Yes <input type="checkbox"/> No		
II. Physician Information		
Physician Name:		
Address (Number, Street, Suite #)	City	Zip Code
Telephone Number	Fax Number	

Please note that the information on this form is being collected to determine eligibility for benefits under the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87) and is required by the California Department of Public Health (CDPH), Office of AIDS. The information may be used to determine eligibility for insurance assistance. Failure to provide the mandatory information may result in the application not being processed. You have the right to review the information maintained by CDPH unless access is exempt by law. To access the information, contact CDPH Insurance Assistance Section, MS 7704, P.O. Box 997426, Sacramento, CA 95899-7426, or by phone at (800) 367-2437.

I certify that the information provided on this form is true and correct to the best of my knowledge.

_____ Licensed Health Care Provider Name (Printed)	_____ License Number
_____ Licensed Health Care Provider (Signature)	_____ Date Signed



3. Financial Eligibility Form

FINANCIAL ELIGIBILITY FORM							
Applicant's Name (First, MI, Last)		Date of Birth (mm/dd/yyyy)		Mother's Maiden Name			
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Registered Domestic Partner <input type="checkbox"/> Other _____				Household Size (Please include applicant in this number)			
Applicants who have an adjusted gross income at or below \$50,000 need only to submit <u>their</u> income information and documentation. Applicants with income above \$50,000 must also submit their spouse's income and documentation. Income eligibility will be based on half the combined income.							
Adjusted gross income as stated on applicant's federal or state income tax return: Applicant's Income _____ Spouse's Income _____ Total Adjusted Gross Income \$ _____							
Applicants without a tax return must identify all sources of income and provide the amounts from the applicant's and if applicable spouse's income documentation. If income is not reported as an annual amount, annualize the income (i.e., weekly income x 52)							
Source of Income	Please check all that apply		How much income/money is received?		How often is income/money received? (i.e., weekly, monthly)		Gross Annual Household Income
	Applicant	Spouse	Applicant	Spouse	Applicant	Spouse	
Employment							
Self-Employment							
SSI/SSA							
Social Security Disability Insurance (SSDI)							
State Disability Income (SDI)							
General Assistance/General Relief							
Private Disability							
Unemployment Insurance (UI)							
Retirement/Pension							
Worker's Compensation							
Investment or Interest Income							
Veteran's Administration (VA) Benefits							
Alimony							
Other							
Total Gross Income \$							
Identify the income documentation provided by checking all that apply:							
<input type="checkbox"/> Federal Income Tax Return* <input type="checkbox"/> Disability Award Letter <input type="checkbox"/> Benefit Receipt or Check Stub** <input type="checkbox"/> California State Tax Return* <input type="checkbox"/> Support Verification Affidavit <input type="checkbox"/> Pay Stub** <input type="checkbox"/> W-2 or 1099 Tax Form <input type="checkbox"/> Self-Employment Affidavit <input type="checkbox"/> Bank Statement** (clearly states income source)							
* Copies of Schedule C, W-2 or 1099 tax forms must be included with tax return documents. ** Must provide documentation for 3 current consecutive months.							
Please note that the information on this form is in accordance with the Ryan White HIV/AIDS Treatment and Modernization Act of 2009 and is required by the California Department of Public Health (CDPH), Office of AIDS (OA), Insurance Assistance Section.							
I certify that the answers I have given in this form and the documents provided are true and correct to the best of my knowledge. I understand that failure to provide accurate information may result in termination of insurance premium assistance. I also understand that CDPH/OA staff are permitted to request additional income verification if income reported appears to be inconsistent or incorrect.							
Applicant's Signature _____				Date _____			



3. Financial Eligibility Form

- If client earns *less* than \$50,000...
 - ...only submit *client* income information and documentation

Applicants who have an adjusted gross income at or below \$50,000 need only to submit their income information and documentation. Applicants with income above \$50,000 must also submit their spouse's income and documentation. Income eligibility will be based on half the combined income.

Adjusted gross income as stated on applicant's federal or state income tax return:
Applicants Income _____ Spouse's Income _____ **Total Adjusted Gross Income \$** _____

Applicants without a tax return must identify all sources of income and provide the amounts from the applicant's and if applicable spouse's income documentation. If income is not reported as an annual amount, annualize the income (i.e., weekly income x 52)

Source of Income	Please check all	How much	How often is	Gross Annual
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- If client earns *more* than \$50,000
 - ...must *include* spouse's or registered domestic partner's income as well if applicable
 - Eligibility will be based on *half the combined income*



3. Financial Eligibility Form

- If *no tax form submitted*, fill out and provide documentation:
 - ✓ The total amount received from each income source
 - ✓ Frequency monies are received
 - ✓ Annualized amount for each income source

Applicants without a tax return must identify all sources of income and provide the amounts from the applicant's and if applicable spouse's income documentation. If income is not reported as an annual amount, annualize the income (i.e., weekly income x 52)

Source of Income	Please check all that apply		How much income/money is received?		How often is income/money received? (i.e., weekly, monthly)		Gross Annual Household Income	
	Applicant	Spouse	Applicant	Spouse	Applicant	Spouse		
Employment								
Self-Employment								
SSI/SSA								
Social Security Disability Insurance (SSDI)								
State Disability Income (SDI)								
General Assistance/General Relief								
Private Disability								
Unemployment Insurance (UI)								
Retirement/Pension								
Worker's Compensation								
Investment or Interest Income								
Veteran's Administration (VA) Benefits								
Alimony								
Other								
Total Gross Income							\$	



4. Support Verification Affidavit

State: California - Health and Human Services Agency California Department of Public Health

SUPPORT VERIFICATION AFFIDAVIT

The following information is required for applicants who are being supported by another individual/agency, or who are homeless and unable to provide proof of income or residency.

I. Applicant Information

Applicant's Name (First, MI, Last)		Date of Birth (mm/dd/yyyy)		Mother's Maiden Name	
Home Address (Number, Street, Apt #)		City	County	State	Zip Code
Mailing Address (if different than home)		City	County	State	Zip Code
Telephone Number (Home):			Telephone Number (Alternate):		

Check here if currently homeless

The following information is to be completed by any individual who is providing support to the applicant.

II. Support Information

The applicant named above receives the following from me:
 Housing Utilities Food Cash

I expect to continue to provide these items until:

My relationship to the person named above is:

Please note that the information on this form is in accordance with the Ryan White HIV/AIDS Treatment and Modernization Act of 2009 and is required by the California Department of Public Health (CDPH), Office of AIDS (OA), Insurance Assistance Section (IAS).

I certify that the information provided on this form is true and correct to the best of my knowledge.

 Printed Support Provider's Name

 Signature of Support Provider _____
 Date

The following section is to be completed by the agency representative of an agency that provides support and who is able to verify the client's living situation

The above named person receives the following services from this agency:
 Shelter Social services Other _____

I certify that the above named person is (check all that apply) : Homeless with no source of income,
 Homeless, but a resident of California, Other _____

Agency Name		Agency Representative			
Agency Address (Number, Street, Suite #)		City	State	Zip Code	
Agency Telephone Number		Agency Fax Number			



4. Support Verification Affidavit

- Must be submitted by clients who receive financial assistance or are homeless

The following information is required for applicants who are being supported by another individual/agency, or who are homeless and unable to provide proof of income or residency.

I. Applicant Information

Applicant's Name (First, MI, Last)		Date of Birth (mm/dd/yyyy)		Mother's Maiden Name	
Home Address (Number, Street, Apt #)	City	County	State	Zip Code	
Mailing Address (if different than home)	City	County	State	Zip Code	
Telephone Number (Home):			Telephone Number (Alternate):		
<input type="checkbox"/> Check here if currently homeless					

The following information is to be completed by any individual who is providing support to the applicant.

II. Support Information

The applicant named above receives the following from me:

Housing Utilities Food Cash

I expect to continue to provide these items until:

My relationship to the person named above is:

Please note that the information on this form is in accordance with the Ryan White HIV/AIDS Treatment and Modernization Act of 2009 and is required by the California Department of Public Health (CDPH), Office of AIDS (OA), Insurance Assistance Section (IAS).

I certify that the information provided on this form is true and correct to the best of my knowledge.

Printed Support Provider's Name

Signature of Support Provider

Date



4. Support Verification Affidavit

Section I

- *Client* must complete



Section II

- *Client's support entity* must complete
 - Individual/homeless shelter representative



Section III

- *You* must complete



State of California – Health and Human Services Agency California Department of Public Health

SUPPORT VERIFICATION AFFIDAVIT

The following information is required for applicants who are being supported by another individual/agency, or who are homeless and unable to provide proof of income or residency.

I. Applicant Information

Applicant's Name (First, MI, Last)		Date of Birth (mm/dd/yyyy)		Mother's Maiden Name	
Home Address (Number, Street, Apt #)	City	County	State	Zip Code	
Mailing Address (if different than home)	City	County	State	Zip Code	
Telephone Number (Home):			Telephone Number (Alternate):		

Check here if currently homeless

The following information is to be completed by any individual who is providing support to the applicant.

II. Support Information

The applicant named above receives the following from me:

Housing Utilities Food Cash

I expect to continue to provide these items until:

My relationship to the person named above is:

Please note that the information on this form is in accordance with the Ryan White HIV/AIDS Treatment and Modernization Act of 2009 and is required by the California Department of Public Health (CDPH), Office of AIDS (OA), Insurance Assistance Section (IAS).

I certify that the information provided on this form is true and correct to the best of my knowledge.

Printed Support Provider's Name

Signature of Support Provider _____
Date

The following section is to be completed by the agency representative of an agency that provides support and who is able to verify the client's living situation

The above named person receives the following services from this agency:

Shelter Social services Other _____

I certify that the above named person is (check all that apply) : Homeless with no source of income, Homeless, but a resident of California, Other _____

Agency Name		Agency Representative			
Agency Address (Number, Street, Suite #)	City	State	Zip Code		
Agency Telephone Number	Agency Fax Number				



5. Self-Employment Affidavit

State of California – Health and Human Services Agency California Department of Public Health

SELF-EMPLOYMENT AFFIDAVIT

This form is to be completed by self-employed applicants who are unable to provide tax records and/or pay stubs to establish annual income.

Applicant's Name (First, MI, Last)	Date of Birth (mm/dd/yyyy) / /	Mother's Maiden Name
------------------------------------	---------------------------------------	----------------------

I am self-employed. I have listed my total earnings for the past three months from _____ to the present as follows: Month/Year

Month/Year	Type of Work	Monthly Income \$
Month/Year	Type of Work	Monthly Income \$
Month/Year	Type of Work	Monthly Income \$

Total (sum of the three months listed) \$	Estimated Total Gross Income (multiply total by four) \$
--	---

Please note that the information on this form is in accordance with the Ryan White HIV/AIDS Treatment and Modernization Act of 2009 and is required by the California Department of Public Health (CDPH), Office of AIDS (OA), Insurance Assistance Section.

I certify that the information on this form is true and correct to the best of my knowledge. I understand that failure to provide accurate information may result in termination of insurance premium assistance. Furthermore, I agree to immediately notify the Insurance Assistance Section of any changes in my annual income.

Applicant's Signature	Date
-----------------------	------



5. Self-Employment Affidavit

- Must be completed by clients who are self-employed and are unable to provide pay stubs or tax records.

State of California – Health and Human Services Agency California Department of Public Health

SELF-EMPLOYMENT AFFIDAVIT

This form is to be completed by self-employed applicants who are unable to provide tax records and/or pay stubs to establish annual income.

Applicant's Name (First, MI, Last)	Date of Birth (mm/dd/yyyy)	Mother's Maiden Name
I am self-employed. I have listed my total earnings for the past three months from _____ to the present as follows: Month/Year		
Month/Year	Type of Work	Monthly Income \$
Month/Year	Type of Work	Monthly Income \$
Month/Year	Type of Work	Monthly Income \$
Total (sum of the three months listed) \$		Estimated Total Gross Income (multiply total by four) \$
<small>Please note that the information on this form is in accordance with the Ryan White HIV/AIDS Treatment and Modernization Act of 2009 and is required by the California Department of Public Health (CDPH), Office of AIDS (OA), Insurance Assistance Section.</small>		
<small>I certify that the information on this form is true and correct to the best of my knowledge. I understand that failure to provide accurate information may result in termination of insurance premium assistance. Furthermore, I agree to immediately notify the Insurance Assistance Section of any changes in my annual income.</small>		
Applicant's Signature		Date



6. Public Assistance Screening Form

State of California – Health and Human Services Agency		California Department of Public Health
PUBLIC ASSISTANCE SCREENING FORM		
Please print clearly and answer all questions. Failure to provide complete information may delay processing of your application and receiving insurance premium assistance.		
Applicant's Name (First, MI, Last)	Date of Birth (mm/dd/yyyy) / /	Mother's Maiden Name
I. Medi-Cal Screening		
Does applicant currently receive Medi-Cal: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Has applicant recently applied for Medi-Cal: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Date: Type of proof attached: Status: <input type="checkbox"/> Denied <input type="checkbox"/> Pending		
Was applicant referred to apply: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, referral date:		
If not referred to apply for Medi-Cal, select the specific reason and indicate the documentation provided to support the Medi-Cal non-referral reason: <input type="checkbox"/> Disability Denial <input type="checkbox"/> Excess Assets <input type="checkbox"/> Employed <input type="checkbox"/> Receiving Unemployment <input type="checkbox"/> Ineligible Immigrant Medi-Cal non-referral proof: <input type="checkbox"/> Medi-Cal, SSI, SSDI disability denial letter <input type="checkbox"/> Excess assets documentation <input type="checkbox"/> Employment income documentation <input type="checkbox"/> Unemployment insurance documentation <input type="checkbox"/> Other		
II. Medicare Screening		
Does applicant currently receive Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Will the applicant qualify for Medicare in the next 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is the applicant currently receiving income from Social Security Disability Insurance (SSDI)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
III. Veteran's Administration (VA) Screening		
Is applicant eligible for Veteran's Administration (VA) health care benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is applicant able to access health care services and prescription medications through the VA system? <input type="checkbox"/> Yes <input type="checkbox"/> No If no explain here:		
Please note that the information on this form is in accordance with the Ryan White HIV/AIDS Treatment and Modernization Act of 2009 and is required by the California Department of Public Health (CDPH), Office of AIDS (OA), Insurance Assistance Section.		
I certify that the information on this form is true and correct to the best of my knowledge. I understand that failure to provide accurate information may result in termination of insurance premium assistance.		
_____ Applicant's Signature		_____ Date



6. Public Assistance Screening Form

Purposes of Form

- Clients *must apply* for public health assistance if they are eligible
- The Office of AIDS *must ensure* that it is the payer of last resort.

State of California – Health and Human Services Agency
California Department of Public Health

PUBLIC ASSISTANCE SCREENING FORM

Please print clearly and answer all questions. Failure to provide complete information may delay processing of your application and receiving insurance premium assistance.

Applicant's Name (First, MI, Last)	Date of Birth (mm/dd/yyyy)	Mother's Maiden Name
------------------------------------	----------------------------	----------------------

I. Medi-Cal Screening

Does applicant currently receive Medi-Cal: Yes No

Has applicant recently applied for Medi-Cal: Yes No If yes, Date: _____
Type of proof attached: Status: Denied Pending

Was applicant referred to apply: Yes No If yes, referral date: _____

If not referred to apply for Medi-Cal, select the specific reason and indicate the documentation provided to support the Medi-Cal non-referral reason:
 Disability Denial Excess Assets Employed Receiving Unemployment Ineligible Immigrant
Medi-Cal non-referral proof:
 Medi-Cal, SSI, SSDI disability denial letter Excess assets documentation
 Employment income documentation Unemployment insurance documentation Other

II. Medicare Screening

Does applicant currently receive Medicare?
 Yes No

Will the applicant qualify for Medicare in the next 12 months?
 Yes No

Is the applicant currently receiving income from Social Security Disability Insurance (SSDI)?
 Yes No

III. Veteran's Administration (VA) Screening

Is applicant eligible for Veteran's Administration (VA) health care benefits?
 Yes No

Is applicant able to access health care services and prescription medications through the VA system?
 Yes No If no explain here: _____

Please note that the information on this form is in accordance with the Ryan White HIV/AIDS Treatment and Modernization Act of 2009 and is required by the California Department of Public Health (CDPH), Office of AIDS (OA), Insurance Assistance Section.

I certify that the information on this form is true and correct to the best of my knowledge. I understand that failure to provide accurate information may result in termination of insurance premium assistance.

Applicant's Signature

Date



6. Public Assistance Screening Form

- Client must submit
 - Proof they applied for **Medi-Cal** within 30 days of submitting application
 - Medi-Cal determination documents within 150 days of submitting application
- Enrolled Medicare clients **are not eligible** for OA-HIPP

State of California – Health and Human Services Agency
California Department of Public Health

PUBLIC ASSISTANCE SCREENING FORM

Please print clearly and answer all questions. Failure to provide complete information may delay processing of your application and receiving insurance premium assistance.

Applicant's Name (First, MI, Last)	Date of Birth (mm/dd/yyyy)	Mother's Maiden Name
------------------------------------	----------------------------	----------------------

I. Medi-Cal Screening

Does applicant currently receive Medi-Cal: Yes No

Has applicant recently applied for Medi-Cal: Yes No If yes, Date: _____
Type of proof attached: _____ Status: Denied Pending

Was applicant referred to apply: Yes No If yes, referral date: _____

If not referred to apply for Medi-Cal, select the specific reason and indicate the documentation provided to support the Medi-Cal non-referral reason:

Disability Denial Excess Assets Employed Receiving Unemployment Ineligible Immigrant
Medi-Cal non-referral proof:
 Medi-Cal, SSI, SSDI disability denial letter Excess assets documentation
 Employment income documentation Unemployment insurance documentation Other

II. Medicare Screening

Does applicant currently receive Medicare?
 Yes No

Will the applicant qualify for Medicare in the next 12 months?
 Yes No

Is the applicant currently receiving income from Social Security Disability Insurance (SSDI)?
 Yes No

III. Veteran's Administration (VA) Screening

Is applicant eligible for Veteran's Administration (VA) health care benefits?
 Yes No

Is applicant able to access health care services and prescription medications through the VA system?
 Yes No If no explain here: _____

Please note that the information on this form is in accordance with the Ryan White HIV/AIDS Treatment and Modernization Act of 2009 and is required by the California Department of Public Health (CDPH), Office of AIDS (OA), Insurance Assistance Section.

I certify that the information on this form is true and correct to the best of my knowledge. I understand that failure to provide accurate information may result in termination of insurance premium assistance.

Applicant's Signature

Date



7. Consent Form

INSURANCE ASSISTANCE SECTION CONSENT FORM			
Consent to Participate and Consent to Release Personal and Medical Information Client Eligibility			
<p>Insurance Assistance Section (IAS) is administered by the California Department of Public Health (CDPH), Office of AIDS (OA) to provide health insurance premium payment assistance to low-income individuals living with human immunodeficiency virus (HIV). Individuals applying for IAS services must meet eligibility standards. Services are only available to individuals living with HIV/AIDS who reside in California, are at least 18 years old, and have a federal adjusted gross income below \$50,000. To verify eligibility for this program, CDPH, or its agents may be required to obtain personal information from other agencies or health care providers. If you agree to take part in IAS, the enrolling agency will collect personal information including your name, date of birth, address, Social Security Number, medical history, and financial eligibility for the program. The information will be considered confidential, but may be released to health care providers, and CDPH staff, for the sole purpose of administering the program. Information that you provide for your application may be made available to your local health department for statistical and research purposes. This information includes, but is not limited to, gender, ethnicity, zip code, diagnosis status, and date of birth. This information may also be used for research and professional writings under strict assurances that all identifying information including name and Social Security Number is deleted. Any professional or research reports that may be published will not use your name nor any personal identifying information. Confidentiality agreements are in place, which keep client information confidential except with specific client consent or as otherwise allowed by law.</p> <p>I, _____, consent to release of personal and medical information as described above to CDPH, other health care professionals who provide services to me, and other governmental or public agencies as necessary to determine my eligibility for IAS services. This consent shall remain in effect for two years from the date of my signature below unless revoked by me in writing. A photocopy of the authorization shall be considered as valid as the original. All laws regarding confidentiality of any and all information provided shall be strictly adhered at all times. Any disclosure authorized by the consent form shall be made only upon agreement that the information will be kept confidential.</p>			
_____ Applicant's Signature	_____ Date		
_____ Enrollment Worker's Name	_____ Date		
_____ Enrollment Worker's Signature	_____ Date		
Agency Name	Agency Representative	Agency Telephone Number	
Agency Address (Number, Street, Suite #)	City	State	Zip Code



7. Insurance Assistance Consent Form

- Allows CDPH to release client demographic information for administrative and/or research related purposes.
- Must be signed by the client *and* Enrollment Worker

**INSURANCE ASSISTANCE SECTION
CONSENT FORM**

Consent to Participate and Consent to Release Personal and Medical Information Client Eligibility

Insurance Assistance Section (IAS) is administered by the California Department of Public Health Office of AIDS (OA) to provide health insurance premium payment assistance to low-income individuals living with human immunodeficiency virus (HIV). Individuals applying for IAS services must meet certain eligibility standards. Services are only available to individuals living with HIV/AIDS who reside in California, are at least 18 years old, and have a federal adjusted gross income below \$50,000. To verify eligibility, the program, CDPH, or its agents may be required to obtain personal information from other agencies and health care providers. If you agree to take part in IAS, the enrolling agency will collect personal information including your name, date of birth, address, Social Security Number, medical history, and other information necessary to determine your eligibility for the program. The information will be considered confidential, but may be released to health care providers, and CDPH staff, for the sole purpose of administering the program. Information you provide for your application may be made available to your local health department for statistical and research purposes. This information includes, but is not limited to, gender, ethnicity, zip code, date of birth, marital status, and date of birth. This information may also be used for research and professional purposes under strict assurances that all identifying information including name and Social Security Number will be deleted. Any professional or research reports that may be published will not use your name nor any personal identifying information. Confidentiality agreements are in place, which keep client information confidential except with specific client consent or as otherwise allowed by law.

I, _____, consent to release of personal and medical information as described above to CDPH, other health care professionals who provide services to me, and other governmental or public agencies as necessary to determine my eligibility for IAS services. This consent shall remain in effect for two years from the date of my signature below unless revoked by me in writing. A photocopy of the authorization shall be considered as valid as the original. All laws regarding confidentiality of any and all information provided shall be strictly adhered at all times. Any disclosure authorized by the consent form shall be made only upon agreement that the information will be kept confidential.

Applicant's Signature _____	Date _____		
Enrollment Worker's Name _____	Date _____		
Enrollment Worker's Signature _____	Date _____		
Agency Name _____	Agency Representative _____	Agency Telephone Number _____	
Agency Address (Number, Street, Suite #) _____	City _____	State _____	Zip Code _____



8. Client Report Form

CLIENT REPORT FORM

Applicant's Name (First, MI, Last)	Date of Birth (mm/dd/yyyy) / /	Mother's Maiden Name
Race/Ethnicity (Check all that apply): <input type="checkbox"/> White, non-Hispanic <input type="checkbox"/> African American (non-Hispanic) <input type="checkbox"/> African American/Black <input type="checkbox"/> Caribbean, not Puerto Rican or Cuban <input type="checkbox"/> African/Black <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> East Asian <input type="checkbox"/> South Asian <input type="checkbox"/> Southeast Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other _____ <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Mexican/Mexican American <input type="checkbox"/> Cuban <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Central American <input type="checkbox"/> South American <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____ <input type="checkbox"/> American Indian, Aleutian, Native Alaskan, Eskimo <input type="checkbox"/> Unknown or declined		
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Other _____ <input type="checkbox"/> Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Declined		
HIV Diagnosis: <input type="checkbox"/> HIV <input type="checkbox"/> AIDS <input type="checkbox"/> Disabled due to HIV/AIDS <input type="checkbox"/> Disabled due to _____ <input type="checkbox"/> Not Disabled		
Income: Household Monthly Income _____ Number of Persons in Household _____		
Receiving Public Assistance (other than Medi-Cal): <input type="checkbox"/> SSI <input type="checkbox"/> SDI <input type="checkbox"/> SSDI <input type="checkbox"/> General Assistance <input type="checkbox"/> Other _____		
<p>■ Please note that the information on this form is in accordance with the Ryan White HIV/AIDS Treatment and Modernization Act of 2009 and is required by the California Department of Public Health (CDPH), Office of AIDS (OA), Insurance Assistance Section (IAS).</p> <p>■ All client-level data for Ryan White Program services managed through the California Department of Public Health, Office of AIDS (OA) are entered into the AIDS Regional Information and Evaluation System (ARIES). ARIES is a highly secure, confidential, customized, Web-based, centralized client management system that provides a single point of entry for clients and allows for coordination of client services among providers. ARIES is intended to enhance services to clients by helping providers automate, plan, manage, and report on client services. At provider sites, clients sign an ARIES consent form choosing whether or not to share their information with other agencies they seek services from; this "sharing" allows clients to receive services from additional ARIES providers without having to carry a copy of their doctor's letter, proof of income, and/or living situation to each agency. ARIES is designed to save time for the clients and help ensure quick access to needed services.</p> <p>If a person ONLY receives health insurance premium assistance through the Insurance Assistance Program, then their personal information in ARIES will NOT be shared with any other ARIES providers. However, should an approved IAS client visit another ARIES provider, the client will sign an ARIES consent form at that agency and choose whether or not to share their ARIES data.</p> <p>■ If a person is receiving care services other than health insurance premium assistance and is already entered into ARIES as a "share client" at the time of their health insurance premium assistance enrollment, their share status will remain as "share" and not be changed to "non-share."</p> <p>■ I understand that as a condition of receiving services, I consent that my ARIES information may be made available to my local health department, to local fiscal agents who fund the services I receive, and to OA for mandated care and treatment reporting, program monitoring, statistical analysis, and research activities. This data includes, but is not limited to, demographic, financial, and service information.</p> <p>■ I understand that this consent remains in effect for three (3) years from the date I sign this form, unless I change my share status before that date by signing a new ARIES Consent Share/Non-share Consent Form.</p> <p>■ I certify that the answers I have given in this form are true and correct to the best of my knowledge.</p>		
_____ Applicant's Signature	_____ Date	



8. Client Report Form

- Allows CDPH to collect client demographic information

- Gender
- Household Income
- HIV Diagnosis
- Public Assistance

- Must be signed by applicant

State of California - Health and Human Services Agency
California Department of Public Health

CLIENT REPORT FORM

Applicant's Name (First, MI, Last)	Date of Birth (mm/dd/yyyy)	Mother's Maiden Name
Race/Ethnicity (Check all that apply): <input type="checkbox"/> White, non-Hispanic <input type="checkbox"/> African American (non-Hispanic) <input type="checkbox"/> African American/Black <input type="checkbox"/> Caribbean, not Puerto Rican or Cuban <input type="checkbox"/> African/Black <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> East Asian <input type="checkbox"/> South Asian <input type="checkbox"/> Southeast Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other _____ <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Mexican/Mexican American <input type="checkbox"/> Cuban <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Central American <input type="checkbox"/> South American <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____ <input type="checkbox"/> American Indian, Aleutian, Native Alaskan, Eskimo <input type="checkbox"/> Unknown or declined		
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Other _____ <input type="checkbox"/> Declined		
HIV Diagnosis: <input type="checkbox"/> HIV <input type="checkbox"/> AIDS <input type="checkbox"/> Disabled due to HIV/AIDS <input type="checkbox"/> Disabled due to _____ <input type="checkbox"/> Not Disabled		
Income: Household Monthly Income _____ Number of Persons in Household _____		
Receiving Public Assistance (other than Medi-Cal): <input type="checkbox"/> SSI <input type="checkbox"/> SDI <input type="checkbox"/> SSDI <input type="checkbox"/> General Assistance <input type="checkbox"/> Other _____		
<p>■ Please note that the information on this form is in accordance with the Ryan White HIV/AIDS Treatment and Modernization Act of 2009 and is required by the California Department of Public Health (CDPH), Office of AIDS (OA), Insurance Assistance Section (IAS).</p> <p>■ All client-level data for Ryan White Program services managed through the California Department of Public Health, Office of AIDS (OA) are entered into the AIDS Regional Information and Evaluation System (ARIES). ARIES is a highly secure, confidential, customized, Web-based, centralized client management system that provides a single point of entry for clients and allows for coordination of client services among providers. ARIES is intended to enhance services to clients by helping providers automate, plan, manage, and report on client services. At provider sites, clients sign an ARIES consent form choosing whether or not to share their information with other agencies they seek services from; this "sharing" allows clients to receive services from additional ARIES providers without having to carry a copy of their doctor's letter, proof of income, and/or living situation to each agency. ARIES is designed to save time for the clients and help ensure quick access to needed services.</p> <p>If a person ONLY receives health insurance premium assistance through the Insurance Assistance Program, then their personal information in ARIES will NOT be shared with any other ARIES providers. However, should an approved IAS client visit another ARIES provider, the client will sign an ARIES consent form at that agency and choose whether or not to share their ARIES data.</p> <p>■ If a person is receiving care services other than health insurance premium assistance and is already entered into ARIES as a "share client" at the time of their health insurance premium assistance enrollment, their share status will remain as "share" and not be changed to "non-share."</p> <p>■ I understand that as a condition of receiving services, I consent that my ARIES information may be made available to my local health department, to local fiscal agents who fund the services I receive, and to OA for mandated care and treatment reporting, program monitoring, statistical analysis, and research activities. This data includes, but is not limited to, demographic, financial, and service information.</p> <p>■ I understand that this consent remains in effect for three (3) years from the date I sign this form, unless I change my share status before that date by signing a new ARIES Consent Share/Non-share Consent Form.</p> <p>■ I certify that the answers I have given in this form are true and correct to the best of my knowledge.</p>		
Applicant's Signature	Date	

Questions





Application Requirements

- Clients already enrolled in ADAP will be required to submit *fewer* forms
- Recertification will require *fewer* forms than initial enrollment and annual re-enrollment
- *But...*



Application Requirements

- ...*All* supporting documentation *must* be included to process initial application or recertification
- ...*and....*





Application Requirements

- OA must receive application by **1st day of the month** for client to be enrolled in PCIP the following month
 - Application received and approved by September **1st**
 - → PCIP Insurance effective **October 1**
 - Application received and approved September **2-30**
 - → PCIP Insurance effective **November 1**



Application Processing

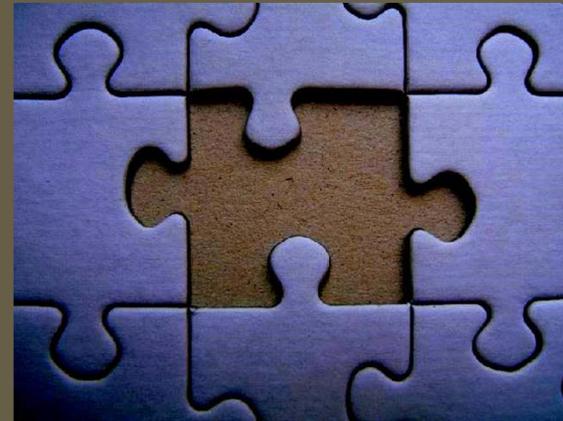
- Recertification & Re-enrollment
- Complete vs. incomplete
- Approved vs. denied





Incomplete Applications

- You should ensure that all forms have been filled out correctly and include ***all*** supporting documentation ***before*** sending to OA
- If application packet is incomplete, the assigned analyst will contact and work with you to resolve the issue
- Incomplete applications ***may delay*** the client's approval



Denied Applications

- A letter explaining the reason for OA-PCIP denial is *immediately* sent to you.
- Note – Denied PCIP application will be forwarded to MRMIB
- It is possible that an applicant will not be eligible for OA-PCIP, but will be eligible for PCIP





Approved Applications

- Letter is sent to you after PCIP has approved the application.
- Payments are made directly to PCIP monthly





OA-PCIP Client Invoice

- Approved OA-PCIP clients will receive a bill monthly from MRMIB
- The bill will be watermarked and will state in part “Premium Paid by OA-PCIP”

CALIFORNIA PCIP
Pre-Existing Condition Insurance Plan

PO BOX 537031
SACRAMENTO, CA 95853-7031

For Questions Contact:
By Phone: 1-877-428-5060
Monday to Friday 8am to 8pm and
Saturday 8am to 5pm
On the Web: www.pcip.ca.gov

We must receive your payment by the due date, in order for you to stay enrolled!

Monthly Billing Statement

Applicant Name: AMBER WAYMENT
Member Number: PC0000900

Amount Due: \$625.00
Due Date: 5/15/2011

MEMBER ENROLLED: AMBER WAYMENT

ACCOUNT SUMMARY

Previous Balance on Account	\$ 625.00
Payment Received on 4/13/2011	- \$ 625.00
Charges for June 2011	\$ 625.00

IMPORTANT NOTES

This statement is a courtesy notice to you as an OA-PCIP subscriber. The California Office of AIDS and the OA-PCIP program has been billed for your premium.

A revised **Summary Plan Description (SPD)** booklet is now available. This document replaces the Temporary SPD. The revised SPD is effective March 1, 2011.

For more details on both of the PCIP program changes, please go to: www.pcip.ca.gov

STATEMENT DATE: May 1, 2011

Total Amount Due: \$ 625.00

FOR PAYMENT BY MAIL ONLY: Write your Member Number on your check. Send your check along with this statement stub to:
Pre-Existing Condition Insurance Plan
PO BOX 537031
SACRAMENTO, CA 95853-7031

Yes My Address Changed!
(Please make corrections on stub)

Sign me up for Electronic Fund Transfer! To sign up for automatic payment, check the box above. Then, fill out the back of this stub, and attach the necessary documents.

AMBER WAYMENT
PO BOX 142
FOLSOM, CA 95630

Please Return This Portion with Your Payment

Member Number: PC0000900
Payment Due Date: 5/15/2011

Amount Due: \$625.00	Amount Enclosed:
--------------------------------	-------------------------

Yes My Phone number Changed!
(New phone number)



Recertification & Re-enrollment

Recertification

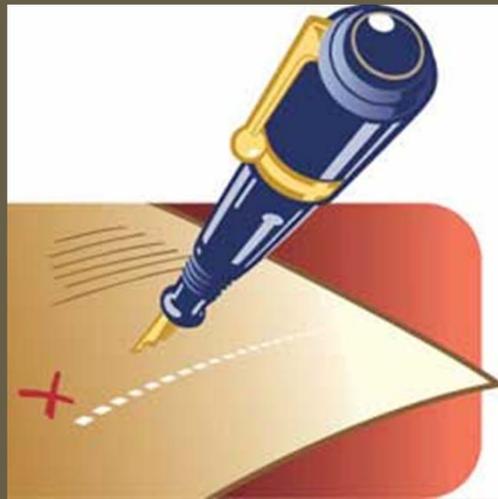
- Occurs six months after client's birthday
- Validate CA residency and sign OA-PCIP Application

Re-Enrollment

- Occurs annually on client's birthday
- Ensure client continues to meet all program requirements
 - New application and all supplemental documentation required

Syncing Recertification

- **When** re-certification/re-enrollment cycle **starts** depends upon:
 1. Month client originally enrolled
 2. Client's birthday month





Goal

- Re-enroll *during* birthdate month
- Re-certify six months *after* birthdate month





Birthday Month Matters

- **Cycle 1**
 - Initially enroll *during birthday month*
- **Cycle 2**
 - Birthday month occurs **2 to 6** months *after* initial enrollment
- **Cycle 3**
 - Birthday month occurs **7 to 12** months *after* initial enrollment





Cycle 1

- Client enrolls during birthday month
 - Re-*certify* six months *after* each birthday
 - Re-*enroll* during every *birthday month*





Cycle 1 Example

Initial Enrollment Month *January*

Birthday Month *January*

Re-Certification *July*

Re-Enrollment *January*

Re-Certification *July*

Re-Enrollment *January*

Etc. Etc. Etc.



Cycle 2

- If birthday month occurs 2 – 6 months *following* initial enrollment
 - **First** re-certification during next birthday month
 - Re-certify six months following every birthday month
 - Re-enroll during the second birthday month following initial enrollment and every birthday month thereafter





Cycle 2 Example

Initial Enrollment Month *January*

Birthday Month *April*



Cycle 3

- If birthday month occurs 7 to 12 months *following* initial enrollment
 - Re-enroll during every birthday month
 - Re-certify six months after each birthday
 - *Similar* to Cycle 1 but...





Cycle 3 Example

Initial Enrollment Month *January* Birthday Month *September*





Contact Information

- Direct all inquiries to ias@cdph.ca.gov *and* to your analyst
- Analysts are assigned to clients by client's last name.
 - A-L
 - Jim Sviben: jim.sviben@cdph.ca.gov
 - M-O
 - Benita White: benita.white@cdph.ca.gov
 - P-Q
 - Jill Young: jill.young@cdph.ca.gov
 - R-S, PRC
 - Kathy Whitaker: kathy.whitaker@cdph.ca.gov
 - T-Z
 - Justine Blanco: justine.blanco@cdph.ca.gov
- Or fax to (916) 449-5860.





Centralized Enrollment

- The preferred mechanism for enrollment into OA-PCIP is through the enrollment worker
- Clients can apply directly to OA
- Applications are available for download at www.cdph.ca.gov/programs/aids.....
- Clients can also call the OA hotline at 800.367.2467 for technical assistance
- Assigned OA analyst will function as an Enrollment Worker and help the client enroll





New Enrollment Workers

- To become an OA-PCIP Enrollment Worker:
 - Complete this training
 - Complete anonymous survey at:
<http://www.surveymonkey.com/s/VNH29H8>
 - Take a short quiz and provide contact information at:
<http://www.surveymonkey.com/s/V9QXKH8>
 - You will **not** be certified as an OA-PCIP Enrollment Worker if you do not take the quiz.
- Annual Recertification required



questions
anyone?

