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

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OFFICE OF AIDS (OA)
AIDS DRUG ASSISTANCE PROGRAM (ADAP)

Management Memorandum
Memorandum Number: 2017-02

DATE: FEBRUARY 16, 2017

TO: LOCAL ADAP COORDINATORS AND ADAP ENROLLMENT WORKERS

SUBJECT: MODIFIED SELF-VERIFICATION FORM

The purpose of this memo is to inform enrollment workers that the ADAP Self-Verification Form (SVF) has been modified; specifically the income verification question.

If the client's annual household income has changed but it is still within the program income eligibility requirements, the client does **not** need to meet with his/her enrollment worker or provide supporting income documentation.

If the client's annual household income has changed and the income is outside of the program income eligibility requirements, the client will need to meet with his/her enrollment worker and provide supporting income documentation. The enrollment worker will need to verify that the client does not meet program income eligibility requirements and notify ADAP that the client is no longer eligible for the program.

Please see the new SVF attached to this memo. The new SVF is effective March 2017. Please note that clients whose eligibility has been extended will not have their eligibility end date listed on their SVF. Instead, the SVF will state "your eligibility is ending soon".

If you have any questions, please contact your ADAP Advisor.

Thank you,

Majel Arnold, Acting ADAP Branch Chief
California Department of Public Health

SELF-VERIFICATION FORM (SVF)

Date: _____ Client ID #: _____

Dear Client,

Your eligibility for the prescription and (if applicable) insurance assistance program will end on: _____/_____/_____. Follow the steps below to complete and return this form before the expiration date. If you do not complete this form, you risk being dis-enrolled from the program that pays for your medications and (if applicable) health insurance costs.

STEP 1 – REVIEW AND VERIFY YOUR ELIGIBILITY INFORMATION

	The most current information in our database is listed below ↓↓↓		Is the information correct?
A	Residential address or living situation *(your mailing address may be different)*		☐ Yes ☐ No
B	Current annual household income	$ *If your household income has changed but it is still within the program income eligibility limits, please mark "Yes". See income table on the back of this form.*	☐ Yes ☐ No
C	Health Insurance Coverage		☐ Yes ☐ No

If you are a Health Insurance Premium Payment (HIPP) client: You must submit a copy of your most recent health insurance billing statement along with your completed SVF. **If you do not submit a copy of your most recent health insurance billing statement, your insurance assistance may be canceled.** If you are enrolled in Medicare Part D, you do not need to submit a billing statement.

STEP 2 – RETURN THE SELF-VERIFICATION FORM

If you answer "YES" to box 'A', 'B', and 'C' above : (1) Read the *Client Acknowledgement* below; and **(2)** Return this completed form by mail to SVF Processing Center, 4660 S. Hagadorn Rd. Suite 290, East Lansing, MI 48823, using the pre-paid envelope provided. You can also return the form to your Enrollment Worker/enrollment site before your eligibility end date highlighted at the top of this page.

If your answer is "NO" to box 'A', 'B', and/or 'C' above: Do Not Return This Form by Mail. You must contact your Enrollment Worker/enrollment site to complete your eligibility recertification process before the eligibility end date highlighted at the top of this page. Take this form and your supporting eligibility documentation with you when you meet with your Enrollment Worker.

Client Acknowledgement

I am providing information on this form to continue my eligibility for the program. I understand that I may be denied program services if I have given false information or if I fail to give complete information by the eligibility end date above. By signing below, I certify, to the best of my knowledge, the information provided is true and correct.

Client Name (print): _____

Client Signature (required): _____ **Date:** _____/_____/_____

If you have questions or need help completing this form, please contact your Enrollment Worker. Or you can contact a representative at 1-844-550-3944. More information can be found at CAMEDAssist.org.

2016 Program Income Eligibility Requirement

To be eligible for the program, individuals must have a Modified Adjusted Gross Income (MAGI) that is above 138% Federal Poverty Level (FPL) and below 500% FPL (column B and C in the table below).

A	B	C
Household Size	**Medi-Cal Expansion (MCE) eligible*:** Income equal to or below 138% FPL	**Prescription/Insurance Assistance Program limit:** Income equal to or below 500% FPL
1	$16,395	$59,400
2	$22,108	$80,100
3	$27,821	$100,800
4	$33,534	$121,500
5	$39,247	$142,200
6	$44,961	$162,900
7	$50,688	$183,650
8	$56,429	$204,450

For families/households with more than 8 persons, add $4,160 for each additional person.

How to read the table:

1. Identify the number of people in your household in column A.
   Your household size includes your spouse, registered domestic partner, and any dependent(s) that you and/or your spouse or registered domestic partner claim on your tax return.
2. To continue to be eligible for the prescription/insurance assistance program, your income must be more than column B* and must be equal to or less than column C.
   Example: A married couple with no children is a household size of 2. This household has an income of $73,350. The client enrolled in medication and/or insurance assistance is eligible.
   Example: A single person living with 3 roommates is a household size of 1. This household has an income of $14,500. The client is no longer eligible for prescription/insurance assistance and should enroll in Medi-Cal Expansion.*

If it looks like you no longer qualify for the program, please contact your enrollment worker for review.

*Applies only to lawfully present California residents.