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



EDMUND G. BROWN JR.
Governor

OFFICE OF AIDS (OA)
AIDS Drug Assistance Program (ADAP)

Management Memorandum
Memorandum Number: 2014-08

Date: July 24, 2014

TO: LOCAL ADAP COORDINATORS
ADAP ENROLLMENT WORKERS

SUBJECT: 1) **Bi-Annual Eligibility Recertification Implementation; and,**
2) **Mandatory Enrollment Worker Webinar Training Dates**

Effective August 15, 2014, ADAP client bi-annual eligibility recertification will be implemented. On this date, the ADAP Pharmacy Benefits Manager (PBM), Ramsell Corporation, will begin mailing Self-Verification Forms (SVF) to ADAP clients whose bi-annual eligibility recertification is due on or after October 1, 2014. The SVF and an explanatory cover letter will be mailed 45 days prior to a client's bi-annual eligibility recertification due date. For your reference, a sample SVF and cover letter are attached.

The Human Resources and Services Administration (HRSA) Ryan White (RW) Part B Program Monitoring Standards mandate that grantees screen RW (ADAP) clients for program eligibility every six months. It is ADAP's goal to implement the HRSA-mandated bi-annual recertification requirement in a manner that supports continued client access to ADAP services while providing clients and enrollment workers (EWs) with an efficient recertification process.

In preparation for the new bi-annual eligibility recertification process, all ADAP EWs will be **required** to enroll and complete **Bi-Annual Eligibility Recertification Process webinar training**. This is to inform you that webinars will be conducted mid-August.

July 24, 2014

Webinar training dates:

<u>Date</u>	<u>Time</u>
August 12, 2014	1:30 pm – 3:30 pm
August 13, 2014	10:00 am – 12:00 pm
August 14, 2014	9:00 am – 11:00 am

The two hour training timeframe includes an estimated one and a half (1.5) hours of actual training time, which will consist of a review of the SVF and related processes, including a client on-line bi-annual recertification option. The timeframe also includes an estimated half (0.5) hour for a question and answer session at the end of the training. EWs who do not complete the required training by the final date listed above will be suspended. Additional information on the webinar, including registration, webinar link and access codes, will be provided to EWs by the ADAP PBM prior to the training dates. EWs are required to register for one of the following Bi-Annual Recertification Process trainings.

Please contact your OA ADAP Advisor if you have any questions regarding the information provided in this memo. The most current "OA/ADAP Staff Assignments by LHJ" list is available on the OA website at:

<http://cdphinternet/programs/aids/Documents/ADAP-LHJStaffAssignments.pdf>

Celia Banda-Brown, Chief
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Attachments



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<name>
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<date>

IMPORTANT INFORMATION

ACTION REQUIRED TO CONTINUE ELIGIBILITY FOR YOUR PRESCRIPTION DRUG ASSISTANCE

Dear Client:

When you last enrolled or recertified into the California Department of Public Health's program to get help with your prescription drug coverage, you were told that you would have to recertify your eligibility for the program every six months instead of every year. To meet this federal requirement, **you must** complete, sign, date, and return the attached Self-Verification Form (SVF) before your eligibility end date in order to assure you have continued access to your medications and there is no interruption in your care. You will find your eligibility end date at the top of the SVF.

You may also log on to the SVF website at <https://www.svf.com/california> to complete the SVF. Enter your unique code of **<1234>** to complete the SVF if you have no changes to your residency, insurance, and income information. If you have changes this information please contact your Enrollment Worker.

If you are not able to return the form before the eligibility end date or you have any questions, please contact your Enrollment Worker right away.

Also, please be aware that you are still required to return annually, in person, to an enrollment site to complete your "birthdate" eligibility determination.

SELF-VERIFICATION FORM

Client ID # _____

DATE:

Dear Client,

Your program eligibility will end on: ____/____/____. Follow the steps below to complete and return this form before the expiration date or you may not be able to get your medication from the pharmacy.

STEP 1 – REVIEW AND VERIFY YOUR ELIGIBILITY INFORMATION

↓BELOW↓ is the most current information in our database:	Is the eligibility information still correct?
is still my residential address:	<input type="checkbox"/> Yes <input type="checkbox"/> No
\$ is still my annual income:	<input type="checkbox"/> Yes <input type="checkbox"/> No
is still the <u>only</u> prescription coverage I am enrolled in:	<input type="checkbox"/> Yes <input type="checkbox"/> No

STEP 2 – RETURNING THE SELF-VERIFICATION FORM

If you answer “YES” to all three boxes above: **(A)** Read the *Client Acknowledgement* below; and **(B)** Return this completed form by mail to PMDC, 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” in any of the three boxes above: **Do Not Return This Form by Mail.** You must contact your Enrollment Worker/enrollment site to complete your eligibility recertification process before your eligibility end date highlighted at the top of this page. Take this form 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 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: _____
Signature required; forms returned without signature cannot be processed

Date: ____/____/____

If you have questions or need help completing this form, please contact your Enrollment Worker.