INSURANCE ASSISTANCE APPLICATION

Return to:
Insurance Assistance Program (IAP)
3rd Floor, Mills/Jarrett
Box 101106
Columbia, SC 29211

FOR INTERNAL USE ONLY - DO NOT WRITE IN THIS SPACE
Date Received: ____________ Status/Date: ________________
Final Status/Date: ______________________________________
Completed By: ____

Purpose: This form is for applicants applying for assistance with private/commercial insurance coverage.

I. APPLICANT INFORMATION — DAP ID:

Last Name: ___________________________ First Name: _______________________ Full Middle Name: ___________________

Date of Birth: _______/_______/_________ Social Security #: _______-_______-________ Gender: ___________________

Street Address 1: ____________________________________ Street Address 2: ____

City: ______________________________________ State: _________ Zip code: _____________ County: ___________________

Mailing Address: ______________________________________ City: __________________________ Zip: ___________________

Home Phone (______) _________________________________ Other Phone (______) ____________________________________

Ethnicity (check one):
- o Hispanic/Latino (a): o Mexican o Puerto Rican o Cuban o Other__________________
- o Non-Hispanic/Latino (a)

Race (check all that apply):
- o American Indian or Alaskan Native o Black o White
- o Asian: o Asian Indian o Chinese o Filipino o Japanese o Korean o Vietnamese o Other _________________
- o Native Hawaiian or Other Pacific Islander: o Native Hawaiian o Guamanian or Chamorro o Samoan o Other Pacific Islander
- o Unknown o Other______________________

II. ELIGIBILITY INFORMATION (Please attach a separate page for income if more pages are needed for additional household

Enrollee and Other Members in Household	Relationship to Enrollee	Gender	Date of Birth	Place of Employment or Source of Other Income	Estimated **Yearly Gross** Income
Enrollee					

Acceptable documentation: most current pay stubs, most current W2 forms, most current Federal Tax Return, Pensions, Unemployment Compensation, Social Security Benefits, Alimony, Child Support, Workers Compensation, Wage Statement, or Employer letter (on company letterhead, dated and signed with salary information).

NOTE: You must submit a Pharmacy Selection Form, which requires the applicant's signature. A form is available on our website.

III. CERTIFICATION/CONSENT

1. I certify that the information provided in this application is true and correct to the best of my knowledge.
2. I agree to notify the SC Drug Assistance Program (DAP) of any changes to my income or Medicare/Medicaid/Insurance status within 30 days. I will inform DAP if my address changes or if I choose not to participate in the program.
3. I understand that refusal to use third party resources and/or other requirements are reasons for closure to further program sponsorship.
4. I also understand the importance of taking medications as prescribed and that failure to do so may result in my being dropped from the program. If applicable, I certify that information provided regarding the number of household members, family income and insurance benefits is true and correct to the best of my knowledge.
5. I give permission to DAP to verify this information, either through written documentation or electronic files.
6. By my signature, I authorize the release of information pertaining to my participation in DAP to other pharmaceutical companies or pharmacies, as needed. I further authorize the release of information pertaining to my participation in DAP for the purpose of payment or clinical treatment review to the organization(s) associated with the referring physician, referring case manager, and/or case manager if not the referring case manager indicated on the next page.
7. By my signature below as applicant, parent, or guardian, I request that payment of Medicare/Medicaid or other third party insurance benefits be made on my behalf to the SC Department of Health and Environmental Control (DHEC) for any services, including services related to this application, that are provided to me.
8. Permission is also granted to DHEC to exchange the medical or other confidential information as necessary to the Centers for Medicare and Medicaid Services (CMS), its agents or other agents needed to determine benefits for related services.
9. I understand that in order to receive services, correspondence will be sent to the address provided above.

______________________________ ______________________
Applicant's Signature Date

APPLICANT NAME: ____**DOB:** _________________________

IV. BENEFITS INFORMATION (To be completed by the Case Manager, Nurse, or Physician)

Does the applicant have medical insurance with prescription coverage? o Yes* o No Coverage start date: ______/___/______

*** If yes, attach a copy of the front and back of insurance card**
If applying for Insurance Continuation/Premium Assistance, attach a copy of the insurance/COBRA policy

Applying for: o Insurance Copay Assistance **Reimburse Copay To:** o Provider o Pharmacy

o Insurance Continuation/Premium Assistance **Reimburse Premium To:** o Provider
Copay Assistance is required if applying to Continuation/Premium Assistance

If applying for Insurance Continuation/Premium Assistance (available for individual only): **Monthly Premium:** $__________

Does the applicant have Medicaid coverage? o Yes o No Medicaid application pending? o Yes o No

Does the applicant have Medicare Part D coverage? o Yes o No Medicare Part D application pending? o Yes o No

V. CLINICAL INFORMATION (To be completed by the Physician)

Current Disease Stage: o HIV/AIDS Status Unknown o HIV Negative o HIV+, not AIDS

Date of HIV diagnosis: _________/_____/______

Meets the CDC's case definition of AIDS? o Yes o No Date AIDS Diagnosed: _______/_______/______ o Unknown

The applicant's current clinical status is: o Asymptomatic o Symptomatic o Not Indicated

The ***most recent*** CD4 (T4) lymphocyte count was _________________on ______/______/________(date drawn)

The ***most recent*** viral load result was ________________on _____/_____/_____(date drawn) o Pretreatment? o On therapy?

Is the applicant currently on any DAP approved medication? o Yes o No

- If "No." will the applicant be on DAP approved medications in 60 days? o Yes o No

(Applications will be returned as incomplete if both questions are checked "No")

For a full list of approved DAP medications go to the following link: http://www.scdhec.gov/Health/docs

Referring Physician (Print Name)	Signature	Date	Organization (Please Print)	Phone

Address	City	State	Zip Code	State Medical License#	DEA#

Referring Case Manager (Print Name)	Signature	Date	Organization (Please Print)	Phone

Case Manager if NOT the Referring Case Manager (Print Name)	Signature	Date	Organization (Please Print)	Phone

INSURANCE ASSISTANCE PROGRAM (IAP) APPLICATION
Instructions - DHEC 1536

Purpose: This form will be used to provide relevant information to determine the applicant's eligibility for the Insurance Assistance Program (IAP).

Important:
This form must be completed and signed by the applicant AND the applicant's physician or case manager. All of the supporting documentation (including income documentation) must be submitted with the form.

Instructions:

I. Applicant Information

DAP ID: Enter the applicant's DAP ID, if available.
Name: Enter the applicant's last, first, and full middle name.
Date of Birth: Enter the month, day, and year of the applicant's birth.
Social Security Number: Enter the applicant's social security number. Contact DAP if the applicant does not have a social security number.
Gender: Enter the applicant's gender (Male, Female, or Transgender).
If no Social Security # is provided, indicate if the applicant has lived in SC for at least 3 months.
Home Address: Enter the street address where the applicant lives. Do not enter a PO Box.
County: Enter the county name where the applicant lives.
Mailing Address: If different from the street address, enter the address (Street or PO Box #) where the applicant wants to receive medications and other correspondence. *NOTE*: You must notify DAP immediately if there is a change in the mailing address.
Telephone: Enter the area code and telephone number where the applicant can be reached. Please list both home and work numbers, if possible. *NOTE*: You must notify DAP immediately if there is a change in the telephone number.
Ethnicity: Enter the applicant's ethnicity.
Race: Enter the applicant's race.

II. Eligibility Information

Financial Data: List the following in the table:
Place of employment, estimated yearly income of the applicant.
Other members of the household, relationship to the applicant, gender, date of birth, place of employment or source of income. Write "unemployed" if not working - do not write N/A, do not leave blank and do not draw a line through the space.
Proof of income is required for the applicant and for each member of the household listed in the application.
NOTE: The Eligibility Information section is important and must be completed or the form will be returned. Please enter all of the information including a complete list of the household dependents and their individual income documentation (this may be useful in determining if the applicant qualifies for the program).
NOTE: You must submit a Pharmacy Selection Form, which requires the applicant's signature.

III. Certification and Consent

Consent: This section is mandatory. The applicant must read and understand the conditions for acceptance into the program and sign on the line "*Applicant's Signature*" and date the application.

IV. Benefits Information (To be completed by the Case Manager, Nurse, or Physician)

Private Medical Insurance: Check the appropriate box if the applicant has private insurance (through employer, or self). Note the coverage start date.
NOTE: Attach copy of insurance card (back and front); if applying for insurance continuation/premium assistance, attach a copy of the insurance/COBRA documentation.

Copay and/or Continuation/Premium Assistance: Check the appropriate box if the applicant is applying for insurance copay assistance and/or continuation/premium assistance. Select the reimbursement method (to provider/pharmacy).

Continuation/Premium Assistance: Enter the monthly premium amount if applying for continuation/premium assistance. (IAP will only cover health insurance – not dental, vision, etc.).

Proof of HAART may be requested from the applicant/provider.

Medicaid coverage: Check the appropriate box if the applicant has Medicaid coverage.

Medicaid application pending: Check the appropriate box if the applicant's Medicaid application is pending.

Medicare Part D coverage: Check the appropriate box if the applicant has Medicare Part D coverage.

Medicare Part D application pending: Check the appropriate box if the applicant has an application pending for Med D coverage.

V. Clinical Information (This section should be completed by the physician)

Current Disease Stage: Check the appropriate box for the current disease stage.

Date of HIV diagnosis: Enter the date of HIV diagnosis.

Meets the CDC's case definition of AIDS?: Check Yes or No. If Yes, enter the date of AIDS diagnosis or select Unknown if date of AIDS diagnosis is unknown.

Applicant's Current Clinical status: Check the appropriate box for the Current Clinical Status.

CD4 count: Enter the most recent CD4 count and the date the blood was drawn.

Viral load: Enter the most recent Viral Load information and the date the blood was drawn.

Medications: Check the appropriate box. If No, indicate if applicant will be on DAP approved medications in 60 days. Application will be returned as incomplete if both questions are checked No.

Signatures: All applications MUST be signed by the physician and case manager and/or referring case manager. See below for definitions:

Referring physician's signature: The referring physician must sign and date this section. The organization name must be printed clearly.

Referring case manager: The referring case manager, if applicable, must sign and date this section. The organization name must be printed clearly. The referring case manager is typically the applicant's nurse or social worker who actively monitors the applicant's clinical progress and treatment adherence.

Case manager if not the referring case manager: This section is to be completed if the applicant has a case manager who's different from the referring case manager. The case manager should sign and date this section. The organization name must be printed clearly. This case manager is usually a nurse or social worker who assists the applicant with completing the application. In some instances, the application will be forwarded to another nurse or social worker who actively monitors the applicant's clinical progress and treatment adherence.

Office Mechanics

Protected Health Information: This form contains Protected Health Information (PHI) and should be stored and/or disposed in accordance with your organization's privacy policy. Appropriate forms of storage include but are not limited to: 1) in imaged format and secured in your electronic health record (EHR) system, 2) in paper format in each applicant's secure chart/file, 3) shredded in accordance with your organization's privacy policy. This record of disclosure must remain available for a six (6) year retention period.

Completed applications must be submitted into Provide Enterprise by the applicant's Case Manager or mailed to:

Insurance Assistance Program
3rd Floor, Mills-Jarrett
Box 101106
Columbia, SC 29211