



CDAP FACTS

- **Re-certification period has been change to consumer's date or birth each year.**
- **Applications (Only original copies will be accepted for new enrollment)**
 - >New Enrollment – Currently there is no waiting list
 - >Re-Certification – Recertification Questionnaire and supporting documents and updates for the year. (Please see attached document.)
- **New requirement for all Medicare participants, New Enrollment & Re-certification**
 - >Proof consumer has applied for Low Income Subsidy or “Extra Help”
 - > www.ssa.gov/prescriptionhelp/
- **Eligibility**
 - >Proof of Louisiana Residency: State ID, Driver's License, or Utility Bill

 - >Proof of Household Income: 2 most recent paycheck stubs, copy of W-2, SSI/SSDI Award letter, Letter from LA Dept of Labor stating unemployment benefits. For those individuals with NO INCOME, a notarized affidavit including the individual name, social security number and address should be attached.

 - >Copy of all Insurance Cards, including Medicare A and B, Medicare part D, Private and ADAP and Medicaid card.

 - >Copy of Summary of Benefits Schedule for all insurance coverage including Medicare Part D Pharmacy benefits.

 - >Consent to Release form, this form will remain in effect until revoked by the consumer or withdrawal from the program. (see attached)
- **Client may apply for CDAP outside of Case Management**
 - >Application can be obtained from HAART's website at www.haartinc.org , any case management agency or the CDAP Coordinator.
- **Every bill received must be accompanied by an EOB (Explanation of Benefit)**
- **CDAP bills are paid on a bi-weekly basis**
- **CDAP applications are reviewed and approved on a daily basis**

Revised 6/2008

Client Name: _____ DOB: _____

Check List for CDAP New Enrollment

_____ ATTENDING PHYSICIAN'S STATEMENT – Proof of diagnosis

_____ PROOF OF LOUISIANA RESIDENCY

_____ PROOF OF CURRENT INCOME

\$ _____ /year
\$ _____ /month

Last 2 (current) pay check stubs _____
SSI or SSDI award Letter _____
Retirement Letter _____
Other _____

_____ Client meets Income Criteria for CDAP Eligibility

_____ 0-135% _____ 136% -155% _____ 156% - 200% _____ 201% - 250% _____ 251% - 300%

_____ INSURANCE CARDS

Private _____
Medicare A & B _____
Medicare Part D _____

_____ SUMMARY OF BENEFITS

_____ DEDUCTIBLE AMOUNT \$ _____

_____ PROOF OF LIS APPLICATION FOR CURRENT YEAR
(Required for those on Medicare)

_____ Approved _____ Denied

_____ CONSENT TO RELEASE

*******In House*******

_____ Address Review/Entry in CareWare

_____ MasterList Spreadsheet

_____ Medicare Part D/ Private Ins. Spreadsheet

Approved: _____

Date: _____

PLEASE INSERT

**CDAP
New Enrollment
Application**

Here

**Louisiana Co-payment & Deductible Assistance Program
(CDAP)
Attending Physician Statement**

This is to certify Mr./Ms. _____ Chart # _____
(Patient's Name/DOB)

has received/is receiving medical treatment from _____
(Physician Name)

Diagnosis of this patient is:

Please circle one:

_____ HIV Exposed	<u>Adult</u>	<u>Ped</u>
_____ HIV Positive	A1 A2 A3	PO P1
_____ AIDS	B1 B2 B3	P2 Non AIDS
	C1 C2 C3	P2 AIDS

Current CD4 Count _____ **Current Viral Load** _____ **Test Date** _____

_____ Patient has a disabling condition in addition to HIV/AIDS
and/or is disabled due to HIV/AIDS.

Score on the Karnofsky Scale is : _____ (Medical Purposes)

Please list any other medical conditions _____

Attending Physician Signature

Date

Check one if applicable

_____ Above diagnosis based on physician's referral.

_____ Intake only completed at this time. Diagnosis has not yet been determined.

Social Worker Signature

Date

PLEASE FAX BACK TO 225-927-7367 ATTN: CDAP

Consent to Release Information

I, _____ Social Security Number _____, do hereby authorize the Louisiana Co-Payment and Deductible Assistance Program (CDAP) to gain access to all information necessary to carry out co-payment and deductible reimbursements on my behalf. This is subject to medical records and medical account information, insurance premiums and benefits, or information concerning health insurance and employment of myself, spouse, or any dependent. I acknowledge that this authorization is effective for the duration of my health insurance policy or until a request to revoke authorization is submitted. This also constitutes authorization to release and furnish the Health Insurance Continuation Program with such information as premium rates, premium payment information, insurance coverage information, and explanation of benefits.

This authorization shall remain active until a request to revoke authorization is submitted or until I become deemed ineligible to continue participation in the program, either voluntarily or mandated by CDAP, whichever comes first.

Insurance Policy Number _____

Insurance Group Number _____

Patient Signature

Date

Witness Signature

Date

Client Name: _____ DOB: _____

Check List for CDAP Re-Certification

_____ PROOF OF LOUISIANA RESIDENCY

_____ PROOF OF CURRENT INCOME

\$ _____ /year
\$ _____ /month
Last 2 (current) pay check stubs _____
SSI or SSDI award Letter _____
Retirement Letter _____
Other _____

_____ Client meets Income Criteria for CDAP Eligibility

_____ 0-135% _____ 136% -155% _____ 156% - 200% _____ 201% - 250% _____ 251% - 300%

_____ INSURANCE CARDS – (If changed from last year)

Private _____
Medicare A & B _____
Medicare Part D _____

_____ SUMMARY OF BENEFITS – (If changed since last year)

_____ DEDUCTIBLE AMOUNT \$ _____

_____ PROOF of LIS for the CURRENT YEAR
(Required for Medicare recipients)

_____ approved _____ denied

_____ CONSENT TO RELEASE

*****In House*****

_____ Address Review/Entry in CareWare

_____ MasterList

_____ Medicare Part D / Private Insurance Spadsheet

Approved: _____

Date: _____

Louisiana Co-Payment and Deductible Assistance Program (CDAP)

November 10, 2008

Re: Re-certification of eligibility required

CDAP coverage In an effort to continue to provide this assistance for you, we have implemented certain restrictions on payments. CDAP does not assist with co-payments or deductibles for the following:

- In-patient hospital stays;
- Dental services;
- Prescriptions filled by any CVS pharmacy
- Medicare Part D is eligible with appropriate documentation.

CDAP will continue to assist with co-payments and deductibles for physician visits, laboratory costs, eye care services and medications covered by the participants plan.

As a reminder, we encourage the use of Avita Drugs as a preferred pharmacy provider. You may contact Avita Drugs at 1-888-792-8482.

Re-certification of eligibility The recertification process for existing participants has changed; beginning in 2008, instead of using April 1st as the renewal date for all participants, the participant's date of birth will be used as the renewal date. The recertification letter and recertification questionnaire will be sent in advance and you will be given two weeks to submit the application along with supporting documents. If for some reason you have not received recertification information via mail please contact our office.

Remember when completing the recertification please forward the following documents:

1. **Proof of Louisiana Residency**

Provide a copy of your driver's license, identification card, or a recent utility bill in your name at your address.

2. **Documented Proof of Household Income**

Provide a copy of two (2) recent paycheck stubs, your W-2 or tax return for 2007, and/or your SSI/SSDI determination letter, unemployment eligibility letter or worker's compensation letter, if applicable. Participants with no income should provide a signed and notarized "No Income Affidavit."

3. **Copy of all **current** Insurance Cards (includes Medicare card, if applicable) –**

Please omit if coverage has not changed

Additionally, Medicare Part D participants must provide the card for the plan selected at enrollment.

4. **Summary of Benefits Schedule - Please omit if coverage has not changed**

If you have private insurance, you must provide this summary which indicates the policy's scope of coverage and service reimbursement rates. (Annual deductible, co-payments for office visits, laboratory and prescription drug coverage are examples of some of the information provided in this schedule.)

5. **Consent to Release**

This form must be signed and returned with the recertification package.

Please note that failure to provide all requested documentation will result in an incomplete application and delays in processing your assistance. Assistance can only be provided upon the receipt of this information and your re-certification into the program. Completed applications and supporting documentation should be mailed and/or faxed to:

La. Co-payment and Deductible Assistance Program

P.O. Box 66913

Baton Rouge, LA 70896-6913

FAX (225) 927-7367

If you have any questions about this information, our staff will be happy to speak with you. Please call our office toll free at 1-888-647-1269 or (225) 927-1269.

Sincerely,

CDAP Coordinator

2008 CO-PAYMENT AND DEDUCTIBLE ASSISTANCE PROGRAM

H.A.A.R.T.

ATTN: CDAP Recertification Questionnaire

P O BOX 66913

BATON ROUGE LA 70896-6913

Name: _____ **Date of Birth:** _____

Current Phone Number :(____) _____ **Alternate Contact #:** (____) _____

Current Address: _____
Street Address

City State Zip Code

Current Mailing Address: _____
(if different that the address listed above) Street or P.O. Box (where you can receive mailings)

City State Zip Code

Current Insurance Provider: _____

***If Medicare is your provider please list your current Part D Provider:** _____

Is this a change from the provider you had last year? _____ **Annual Deductible:** _____

Current Annual Income: \$ _____ **Income Source:** Earned Income Retirement
(Please circle)

How often are you paid? Weekly Bi-Weekly Unemployment SSI/SSDI
(Please Circle) Monthly Workman's Comp Other

Are you in case management services? _____ **Case Management Agency:** _____

Name of Case Manager: _____ **Phone #:** (____) _____

By signing below I acknowledge that I would like to continue my participation in the Louisiana Co-payment and Deductible Assistance Program (CDAP) for the upcoming year. I also understand that I am to contact either my case management agency or CDAP directly with any changes in income, employment, insurance, address, or contact information immediately following such changes. I also acknowledge that the information and documentation submitted are truthful and current to the best of my knowledge.

Client Signature **Date**

Witness **Date**

Consent to Release Information

I, _____ Social Security Number _____, do hereby authorize the Louisiana Co-Payment and Deductible Assistance Program (CDAP) to gain access to all information necessary to carry out co-payment and deductible reimbursements on my behalf. This is subject to medical records and medical account information, insurance premiums and benefits, or information concerning health insurance and employment of myself, spouse, or any dependent. I acknowledge that this authorization is effective for the duration of my health insurance policy or until a request to revoke authorization is submitted. This also constitutes authorization to release and furnish the Health Insurance Continuation Program with such information as premium rates, premium payment information, insurance coverage information, and explanation of benefits.

This authorization shall remain active until a request to revoke authorization is submitted or until I become deemed ineligible to continue participation in the program, either voluntarily or mandated by CDAP, whichever comes first.

Insurance Policy Number _____

Insurance Group Number _____

Patient Signature

Date

Witness Signature

Date