



CDAP FACTS

- ❖ Re-certification is now the consumer's date of birth each year.
- ❖ Applications (*Only original copies will be accepted for new enrollment*)
 - New Enrollment – Currently there is no waiting list
 - Re-Certification – Recertification application and supporting documents are required annually to maintain participation in the program.
- ❖ New requirement for Medicare recipients both New and Recertifying applications;
 - Proof consumer has applied for Low Income Subsidy or “Extra Help” through the Social Security Administration.
 - www.ssa.gov/prescriptionhelp/
- ❖ Eligibility
 - Proof of Diagnosis
 - 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.
- ❖ 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

Louisiana Co-Payment and Deductible Assistance Program

P.O. Box 66913
Baton Rouge, LA 70896
(888) 647-1269 (toll free phone)
(225) 927-1269 (phone)
(225) 927-7367 (fax)

Dear Applicant,

Thank you for your request to enroll in the Louisiana Co-Payment and Deductible Assistance Program, a federally funded program authorized under Ryan White Title II and administered directly through the Louisiana Office of Public Health.

This program is designed to assist qualified individuals with claims/fees associated with co-payments and deductibles attached to one's private insurance and/or Medicare. In order to qualify for this program, one must demonstrate Louisiana residency, HIV/AIDS diagnosis, meet income guidelines, and indicate proof of primary insurance coverage.

Upon completion of the attached application, please be aware that notification will be sent out to each medical provider (physician's offices, pharmacies, and/or hospitals) listed on your application. Although some individual providers may elect to participate in this program, some providers may not choose to do so. If a provider elects not to participate, it is simply your responsibility to forward your medical bills to this office in a timely manner.

If it is determined that you meet eligibility requirements, an acceptance letter will be mailed to you. Please retain this letter for your records as it provides proof that you are a registered participant in this program.

In addition to completing the attached application, please be sure to attach the following documents in order to determine your eligibility.

1. Proof of Louisiana Residency

-Provide a copy of your driver's license, identification card, or recent utility bill

2. Documented HIV/AIDS Infection

-Provide a completed and signed HIV diagnosis form (see attachment) from your physician

3. Documented Proof of Household Income

-Provide at least three (3) most recent paycheck stubs, W-2, SSI/SSDI determination letter, or worker's compensation letter

4. Copy of all Insurance Cards (includes Medicare Card, if applicable)

-If you have private insurance, you **must** provide Summary of Benefit Schedules indicating scope of coverage and service reimbursement rates

5. Signed Consent to Release Information Form

- Please see attached to find the Consent to Release form. Fill out, sign, date and return to us with the application and supporting documentation.

Please note that failure to provide all five (5) pieces of documentation will result in an incomplete application. If you have any questions concerning your application and/or requirements, it is advised that you contact this office **before application submission** to ensure that is complete. Our toll free telephone number is (888) 647-1269.

Completed applications should be submitted to:

HAART
Attn: CDAP
P.O. Box 66913
Baton Rouge, LA 70896

Thank you for applying to the Louisiana Co-Payment and Deductible Assistance Program (CDAP) and we look forward to assisting you in the future.

Sincerely,

CDAP Coordinator

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: _____

NEW ENROLLMENT APPLICATION
2009/2010 CO-PAYMENT AND DEDUCTIBLE ASSISTANCE PROGRAM

HAART
 ATTN: CDAP
 P O BOX 66913
 BATON ROUGE LA 70896-6913

****Assurance of confidentiality****

All information that you provide as part of this application will be kept strictly confidential to the fullest extent allowable by the law. The information collected and the reported of this project will be in aggregate form only and the identity of any applicants and/or participants will not be revealed under any circumstances, except as necessary to carry out the activities of the program.

REGION: (CIRCLE) 1 2 3 4 5 6 7 8 9 CDAP FILE # _____

Agency: _____ Case Manager: _____ Phone _____

Client Information

1. Name (Last, First, MI)

2. Home Address (street, city, state, zip code)

Can mail be sent to this address? ____yes ____no

Can we contact you by phone? ____yes ____no

Home/Cell Phone Number () _____/ _____

3. Date of Birth

_____/_____/_____

4. Parish of Residence

5. Phone Number

Home () _____-_____

Work () _____-_____

6. Gender

____Male

____Female

____Transgender

7. Social Security Number

_____/_____/_____

8. Ethnicity

____White ____Hispanic

____Black ____Non-Hispanic

____Asian ____American

____Other ____Indian

INCOME AND ASSETS

A household is defined as ALL members related by blood or marriage residing in the same dwelling. If you are claimed as a dependent for income tax purposes provide proof of income of the person claiming you. If your income from any source is '0', enter '0' in the space provided. DO NOT LEAVE ANY BLANKS! You must provide verification of all sources of income and assets (copies of most recent pay stubs, SSD awards letter, 2 current bank statements, etc). If no income, please provide a notarized "0" income state

9. HOUSEHOLD INCOME PER MONTH:

\$ _____ Salary/Wages

\$ _____ SSI/SSD/Social Security*

\$ _____ Alimony / Child Support

\$ _____ Unemployment

\$ _____ Workers' Compensation

\$ _____ Pension / Private Disability

\$ _____ Interest / Dividend Income

\$ _____ Other (specify) _____

\$ _____ TOTAL per month

* I began receiving SSI/SSD payments on ____/____/_____

10. AMOUNT CASH ASSETS:

\$ _____ Savings Account

\$ _____ Checking Account

\$ _____ IRA Account

\$ _____ Money Market Account

\$ _____ Certificate Of Deposit

\$ _____ Pension &/ Private

\$ _____ Additional Residences/ Real Property

\$ _____ Other (Specify) _____

\$ _____ TOTAL

Medical Providers

List the names and addresses of the medical providers which you regularly visit and require assistance with co-payments and deductibles.

Name, Address and Phone# of Medical Provider

Account # _____	Contact Person _____
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Name, Address and Phone# of Medical Provider

Account # _____	Contact Person _____
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Name, Address and Phone# of Medical Provider

Account # _____	Contact Person _____
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INSURANCE INFORMATION

List the names and addresses of each insurance company for in which you may require assistance with paying co-payments or deductibles. This includes medical, dental and vision insurance policies.

Identify each type of insurance company listed as follows: Private policy, COBRA, Group policy (through employer), Medicare Supplemental, High Risk Insurance Pool, Other

Name, Address and Phone # of Insurance Company

Policy # _____	Type of Insurance _____
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Date Deductible Begins _____/_____/_____	Amount of Deductible \$ _____	Amount Paid Year to Date \$ _____
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Amount of Office Visit Co-Payment \$ _____	Amount of Prescription Co-payment \$ _____
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Name, Address and Phone # of Insurance Company

Policy # _____	Type of Insurance _____
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Date Deductible Begins _____/_____/_____	Amount of Deductible \$ _____	Amount Paid Year to Date \$ _____
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Amount of Office Visit Co-Payment \$ _____	Amount of Prescription Co-payment \$ _____
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Name, Address and Phone # of Insurance Company

Policy # _____	Type of Insurance _____
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Date Deductible Begins _____/_____/_____	Amount of Deductible \$ _____	Amount Paid Year to Date \$ _____
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Amount of Office Visit Co-Payment \$ _____	Amount of Prescription Co-payment \$ _____
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11. Employment Status
<input type="checkbox"/> Full Time <input type="checkbox"/> Part-time <input type="checkbox"/> Not Employed

Current Employer (Include contact person, phone number and fax number)

ADDITIONAL REQUIRED INFORMATION

12. ARRANGEMENTS: <input type="checkbox"/> Live alone <input type="checkbox"/> Live w/ Parent or Guardian <input type="checkbox"/> Live w/ spouse or significant other	TOTAL Household # ____ <input type="checkbox"/> Live w/ relatives other than spouse <input type="checkbox"/> Live w/ children or parents who Receive assistance from client	<input type="checkbox"/> Live w/ non relatives who share expenses <input type="checkbox"/> Live in residential facility <input type="checkbox"/> Live in homeless care facility
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13. TYPE OF DWELLING: <input type="checkbox"/> House <input type="checkbox"/> Apartment <input type="checkbox"/> Mobile <input type="checkbox"/> Residential Facility <input type="checkbox"/> Shelter/Homeless	14. Educational Level <input type="checkbox"/> K-8 <input type="checkbox"/> Some College <input type="checkbox"/> 9 th (no degree) <input type="checkbox"/> 10 th <input type="checkbox"/> College Degree <input type="checkbox"/> 11 th <input type="checkbox"/> Graduate Degree <input type="checkbox"/> 12 th	15. Previously incarcerated within the last 6 months? <input type="checkbox"/> yes <input type="checkbox"/> no
		16. Veteran Status: <input type="checkbox"/> Yes <input type="checkbox"/> No

16. I am currently enrolled in the :
 Health Insurance Continuation Program
 AIDS Drug Assistance Program

Signature

a. I declare that all statements made on this data collection form are true and complete to the best of my knowledge. I realize that willful falsification of this information by me will subject me to immediate disqualification from participation in the Co-payment and Deductible Assistance Program.

b. I also understand that if I qualify for participation, CDAP agrees to pay for co-payments and deductibles. CDAP will assist with the expenses of co-payments and deductibles, for me as long as funds are available and this program is in existence.

c. I understand that it is my responsibility to supply the community based organization or CDAP directly with any information related to my co-payment and/or deductible.

d. Furthermore, it is my responsibility to report any changes in my income and/or cash assets.

e. Finally, I will apply for all assistance for which I may be eligible, including, but not limited to Social Security benefits.

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

This is to certify Mr./Ms. _____ Date of Birth _____
(Patient's Name)

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>
	A1 A2 A3		PO P1
_____ HIV Positive	B1 B2 B3		P2 Non AIDS
_____ 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