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

RON CHAPMAN, MD, MPH
Director & State Health Officer

EDMUND G. BROWN JR.
Governor

2013 MEDICARE PART D PREMIUM PAYMENT PROGRAM ENROLLMENT

The California Department of Public Health (CDPH) administers the Medicare Part D Premium Payment Program. The purpose of this program is to pay the monthly Medicare Part D premiums for eligible California residents.

To be eligible for this program you must:

- Be a resident of California;
- Be enrolled in ADAP;
- Be enrolled in a Medicare Part D Prescription Plan*;
- Be at least 18 years old; and
- Not be 100% Full Low Income Subsidy (LIS) or Full-Scope Medi-Cal.

*You can enroll in a Medicare Part D Prescription Plan during Medicare's open enrollment period which occurs October 15 through December 7, 2012. Please visit http://www.medicare.gov/ for more information.

On **November 15, 2012**, CDPH will begin accepting applications for calendar year 2013 enrollment in the **Medicare Part D Premium Payment Program**.

If you are interested in applying, please print, sign, and date all required forms including:

- ✓ Medicare Part D Premium Payment Program application;
- ✓ Consent form; and
- ✓ Client Report form.

Fax all documents to (916) 440-5494 or send to the following address:

California Department of Public Health
MS 7704
P.O. Box 997426
Sacramento, CA 95899-7426

If you fax your application, it is <u>not</u> necessary to mail a hard copy.

After CDPH receives your application, you will receive a letter within two weeks confirming receipt of your application. CDPH will begin processing applications in January 2013 in order to verify Medicare Part D enrollment and monthly premium amounts for calendar year 2013. You will receive a determination letter after your application has been processed.

Clients may apply anytime during the calendar year. However, in order to make payments on your behalf for all of 2013, your application must be postmarked no later than February 28, 2013. For all approved applications postmarked after that date, CDPH will pay retroactively one month from the date the application is received or the balance owed, whichever is greater.

For more information about the Medicare Part D Premium Payment Program, please call 1(800) 367-2437 or email your questions to ias@cdph.ca.gov.

Sincerely,

Richard Martin, Chief
Insurance Assistance Section
California Department of Public Health

2013 MEDICARE PART D PREMIUM PAYMENT PROGRAM APPLICATION

For CDPH Staff Use Only
Date Received/Staff Initial

Please print clearly and complete sections I, II & III. Failure to complete this form will delay processing of your application and Premium Payment Program assistance. Incomplete applications will be returned to sender.

I. Eligibility Criteria

1. Are you currently enrolled in ADAP?	☐ Yes	☐ No
2. Are you currently enrolled in a Medicare Part D Prescription Plan?	☐ Yes	☐ No
3. Do you currently have Full-Scope (free) Medi-Cal?	☐ Yes	☐ No

If you answered "No" to questions 1 or 2 and/or "Yes" to question 3, then you would *not* be eligible for the program.

II. Applicant Information

Applicant's Name (First, MI, Last)	Social Security Number*	Mother's Maiden Name

Home Address (Number, Street, Apt #)	City	County	State	Zip Code
Mailing Address (if different than home)	City	County	State	Zip Code

Primary Telephone Number	Email Address	Date of Birth (mm/dd/yyyy)

Do we have permission to leave a message on your voicemail if we have questions regarding your application or are responding to your call? ☐ Yes ☐ No

III. Medicare Part D Plan Information

Medicare Part D Plan Name (see Member ID card)	Medicare Part D Rx Member ID (see Member ID card)

IMPORTANT: Please note that the information on this form is being collected to determine eligibility for benefits under the Ryan White Treatment Extension Act of 2009 (Public Law 111-87) and is required by the California Department of Public Health (CDPH) *Provision of the Social Security Number is voluntary. The information may be used to contact insurance companies, employers, providers of health care services, and state and county agencies to determine the extent of available health insurance and eligibility for insurance assistance. Failure to provide the mandatory information may result in the application not being processed. You have the right to review the information maintained by CDPH unless access is exempt by law. To access the information contact CDPH Insurance Assistance Section, MS 7704, P.O. Box 997426, Sacramento, CA 95899-7426, or by phone at (800) 367-2437.

AUTHORIZATION: I authorize insurance companies, employers, providers of health care services, and state and county agencies to release information to the CDPH with regard to health insurance premiums and benefits. I authorize payment of refunds to CDPH for premiums paid by the Medicare Part D Premium Payment Program.

DECLARATION: I agree to re-enroll annually as required by the Medicare Part D Premium Payment Program. I agree to inform CDPH of any changes to my health insurance premiums or eligibility requirements for the program as soon as I am aware of these changes. I agree to return to CDPH any refund received from my Part D (prescription) plan due to a change in my premium status. I certify that the answers I have given in this application and the documents provided are true and correct to the best of my knowledge. I understand that failure to provide accurate information may result in termination of health insurance premium assistance.

Signature of Applicant _____ Date _____

CONSENT FORM
INSURANCE ASSISTANCE SECTION

Consent to Participate and Consent to Release Personal and Medical Information for Client Eligibility

The California Department of Public Health (CDPH), Insurance Assistance Section (IAS) administers an insurance premium payment program to assist qualified California residents with paying their insurance premiums. To verify eligibility for this program, CDPH, or its agents may be required to obtain personal information from other agencies or health care providers. If you agree to take part in an IAS program, the enrolling agency will collect personal information including your name, date of birth, address, Social Security Number, medical history, and financial eligibility for the program. The information will be considered confidential, but may be released to health care providers, and CDPH staff, for the sole purpose of administering the program. Confidentiality agreements are in place, which keep client information confidential except with specific client consent or as otherwise allowed by law.

Information that you provide for your application may be made available to your local health department for statistical purposes. This information includes, but is not limited to, gender, ethnicity, zip code, diagnosis status, and date of birth. This information may also be used for professional writings under strict assurances that all identifying information including name and Social Security Number is deleted. Any professional or research reports that may be published will not use your name nor any personal identifying information.

I, _____, consent to release of personal and medical information as described above to CDPH, my enrollment workers, other health care professionals who provide services to me, and other governmental or public agencies as necessary to determine my eligibility for IAS services. This consent shall remain in effect for two years from the date of my signature below unless revoked by me in writing. A photocopy of this consent shall be considered as valid as the original. Any disclosure authorized by the consent form shall be made only upon agreement that the information will be kept confidential.

_____ _____

Applicant's Signature Date

CLIENT REPORT FORM
INSURANCE ASSISTANCE SECTION

Applicant's Name (First, MI, Last)	Date of Birth (mm/dd/yyyy)	Mother's Maiden Name

Race/Ethnicity (Check all that apply):

1. Hispanic: ☐ Yes ☐ No

2. Race (check all that apply) ☐ White ☐ Black ☐ Asian ☐ American Indian or Native Alaskan ☐ Pacific Islander ☐ Other

Gender:

☐ Male ☐ Transgender Male to Female ☐ Other_____
☐ Female ☐ Transgender Female to Male

Income: Household Monthly Income _____ Number of Persons in Household_____

■ Please note that the information on this form is being collected to determine eligibility for benefits under the Ryan White Treatment Extension Act of 2009 (P.L. 111-87) and is required by the California Department of Public Health (CDPH) for that purpose. Failure to provide the mandatory information may result in the application not being processed. You have the right to review the information maintained by CDPH unless access is exempt by law. To access the information contact CDPH Insurance Assistance Section (IAS), MS 7704, P.O. Box 997426, Sacramento, CA 95899-7426, or by phone at (800) 367-2437.

■ All client-level data for Ryan White Program services managed through CDPH are entered into ARIES. ARIES is a highly secure, confidential, customized, Web-based, centralized client management system that provides a single point of entry for clients and allows for coordination of client services among providers. ARIES is intended to enhance services to clients by helping providers automate, plan, manage, and report on client services. At provider sites, clients sign an ARIES consent form choosing whether or not to share their information with other agencies they seek services from; this "sharing" allows clients to receive services from additional ARIES providers without having to carry a copy of their doctor's letter, proof of income, and/or living situation to each agency. ARIES is designed to save time for the clients and help ensure quick access to needed services.
If a person **ONLY** receives health insurance premium assistance through the Insurance Assistance Program, then their personal information in ARIES will **NOT** be shared with any other ARIES providers. However, should an approved IAS client visit another ARIES provider, the client will sign an ARIES consent form at that agency and choose whether or not to share their ARIES data.

■ If a person is receiving care services other than health insurance premium assistance and is already entered into ARIES as a "share client" at the time of their health insurance premium assistance enrollment, their share status will remain as "share" and not be changed to "non-share."

■ I understand that my ARIES information may be made available to my local health department, to local fiscal agents who fund the services I receive, and to CDPH for mandated care and treatment reporting, statistical analysis, program monitoring and evaluation activities. This data includes, but is not limited to, demographic, financial, and service information.

■ I certify that the answers I have given in this form are true and correct to the best of my knowledge.

_____ _____
Applicant's Signature **Date**