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

2014 MEDICARE PART D PREMIUM PAYMENT PROGRAM

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

To be eligible for the program, a client must:

- Be a California resident;
- Be enrolled in the AIDS Drug Assistance Program (ADAP);
- Be enrolled in a Medicare Part D Prescription Plan;
- Be at least 18 years old; and
- Not be 100% Low-Income Subsidy or Full-Scope Medi-Cal

On **November 15, 2013**, CDPH will begin accepting applications for the 2014 calendar year. The following documents must be submitted to apply for the program:

- ✓ Medicare Part D Premium Payment Program application;
- ✓ Insurance Assistance Section Consent form;
- ✓ Insurance Assistance Section ARIES Consent Form;
- ✓ Copy of Medicare Part D Prescription Drug Card; and

Mail To:	Fax To:
California Department of Public Health MS 7704 P.O. Box 997426 Sacramento, CA 95899-7426	(916) 440-5494
Please do not submit duplicate applications. Duplicate applications may cause delays.	

CDPH will send the applicant a confirmation letter within two weeks of receipt of the application and will begin processing them in January 2014. Clients will receive a determination letter after their application has been processed.

Clients may apply anytime during the calendar year. However, in order to make payments on their behalf for all of 2014, application must be postmarked no later than February 28, 2014. 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 contact iaspartd@cdph.ca.gov.

Thank you,

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

2014 MEDICARE PART D PREMIUM PAYMENT PROGRAM APPLICATION

For CDPH Staff Use Only
Date Received/Staff Initial

Please read application and forms, fill out section I, II, III, IV clearly and completely. Failure to complete forms and submit information as requested can either delay processing of your application and payment or your application may be denied.

I. ELIGIBILITY CRITERIA INFORMATION

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 (Last)	
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 if we are responding to your call: ☐ Yes ☐ No

III. MEDICARE PART D INFORMATION (Please send a copy of your Medicare Part D Card)

Medicare Part D Plan Name (see Member ID card)	Medicare Part D Prescription Member ID# (see Member ID card)

IV. DEMOGRAPHIC INFORMATION

1. Hispanic: ☐ Yes ☐ No
2. Race (check all that apply): ☐White ☐Black ☐Asian ☐American Indian or Native Alaskan ☐Pacific Islander ☐Other

☐ Male ☐ Transgender Male to Female ☐ Other
☐ Female ☐ Transgender Female Male

☐ HIV Positive, Disease Stage Unknown ☐ HIV Positive, Symptomatic, not AIDS ☐ CDC Defined AIDS
☐ HIV Positive, Asymptomatic ☐ HIV Positive, Disabling ☐ Disabling AIDS

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.

Applicant's Signature _____ Date _____

INSURANCE ASSISTANCE SECTION
CONSENT FORM

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

The California Department of Public Health, Insurance Assistance Section (IAS) administers programs that provide health insurance premium payment assistance to low-income individuals living with human immunodeficiency virus (HIV). Individuals applying for IAS services must meet eligibility standards. Services are only available to individuals living with HIV/AIDS, who reside in California, are at least 18 years old, and have a federal adjusted gross income below $50,000.

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 IAS, 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 CDPH, enrollment workers, Consolidated Omnibus Budget Reconciliation Act (COBRA) administrators, health insurance companies, employers and employer administered health insurance plans, health care professionals who provide services to you, and other governmental or public agencies as necessary to determine your eligibility and for the purpose of administering the program.

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, enrollment workers, Consolidated Omnibus Budget Reconciliation Act (COBRA) administrators, health insurance companies, employers and employer administered health insurance plans, health care professionals who provide services to me, and other governmental or public agencies as necessary to determine my eligibility for IAS services and to administer the program. 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.

_____ _____

Applicant's Signature Date

_____ _____

Enrollment Worker's Signature Date

Enrollment Site Name		Enrollment Worker Name		
Enrollment Site Address (Number, Street, Suite #)		City	State	Zip Code
Enrollment Site Telephone Number	Enrollment Site Fax Number	Enrollment Worker Email Address		

INSURANCE ASSISTANCE SECTION
ARIES CONSENT FORM

I, _____ *(print full name),* wish to register with the AIDS Regional Information and Evaluation System (ARIES) in order to receive services provided by the California Department of Public Health (CDPH) / Office of AIDS (OA) Health Insurance Premium Payment Program (OA-HIPP) or the Medicare Part D Premium Payment Program. During registration, I will be asked to provide information about myself, including my name, race, gender, date of birth, HIV disease stage and other demographic data.

In addition to providing the above information, I must provide this form along with other program forms and documentation required by CDPH/OA. This Insurance Assistance Section (IAS) ARIES Consent Form is in addition to a county's or agency's ARIES Client Consent Form used to register for other (non-insurance premium payment) HIV programs or services. An IAS ARIES Consent Form will be completed again as part of the annual OA-HIPP/Medicare Part D Premium Payment Program re-enrollment process; if no re-enrollment occurs, consent will expire two years from the date I sign this form.

I understand that the information I provide may be made available to my local health department, other governmental or public agencies and to the CDPH/OA for mandated care and treatment reporting requirements, and may be used for program monitoring, statistical analysis and research activities. This information includes, but is not limited to, gender, ethnicity, birth date, zip code, diagnosis status, and service data. No identifying information, such as name and social security number, will be released, published, or used without my consent, except as allowed by law or to ensure compliance with policy.

Additionally, as a condition of receiving insurance premium services, I consent that my local health department may disclose to my health care providers the minimum necessary of my ARIES information to assist them in complying with HIV reporting laws and regulations, or as allowed by law.

My registration in ARIES does not guarantee services from any other ARIES-using agency. Wait lists or other eligibility requirements may exclude me from services at other ARIES agencies.

By signing this form I consent to the disclosure of my information as described above, and acknowledge that I have been offered a copy of the IAS ARIES Consent Form and have talked about and understand my rights to confidentiality with respect to ARIES with the staff person indicated below. I understand that this form will be stored in my paper file and/or uploaded into my ARIES record.

_____ _____

Signature of Client or Parent/Guardian of Minor Child *Date*