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

Karen L. Smith, MD, MPH
Director & State Health Officer

EDMUND G. BROWN JR.
Governor

2016 MEDICARE PART D PREMIUM PAYMENT PROGRAM

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

Individuals are eligible for Medicare Part D Premium Assistance if they:

- are enrolled in ADAP.
- are enrolled in a Medicare Part D Prescription Plan*.
- are not 100% Extra Help/Full Low Income Subsidy (LIS) or Full-Scope Medi-Cal.

*Plan must be a participating Medicare Part D Provider. For a listing of all participating providers, please visit https://www.medicare.gov/find-a-plan/questions/home.aspx.

On **November 15, 2015**, ADAP will begin accepting application packages for the 2016 calendar year. Application packages must include the following:

- ✓ 2016 Medicare Part D Premium Payment Program application;
- ✓ Insurance Assistance Consent Form; and
- ✓ Copy of your Medicare Part D Prescription Drug Card.

In order to make payments on behalf of the applicant for all of 2016, a complete application package must be **postmarked or faxed no later than February 29, 2016**. For all approved application packages postmarked or faxed after that date, the Medicare Part D Premium Payment Program will approve payment starting the first of the month that the completed application package is received.

Mail To:	Fax To:
California Department of Public Health MS 7704 P.O. Box 997426 Sacramento, CA 95899-7426	(916) 440-5494
*****To expedite processing, we strongly encourage you to submit your application via fax***** It is not necessary for you to mail a copy of your application if you fax it. Please do not submit duplicate applications. Duplicate applications may cause delays.	

Within two weeks of receipt of the application package, the Medicare Part D Premium Payment Program will send the applicant a letter acknowledging receipt of the completed application package, or if the application package is incomplete, the letter will instruct the applicant to submit the missing documents. In January 2016, the Medicare Part D Premium Payment Program will begin processing all complete application packages to verify the applicant's monthly premium and enrollment in the Medicare Part D plan. A determination letter will follow after the application package is processed.

For more information about the Medicare Part D Premium Payment Program, please contact iaspartd@cdph.ca.gov or call (844) 421-7050.

Thank you,

Niki Dhillon, ADAP Branch Chief
California Department of Public Health

2016 MEDICARE PART D PREMIUM PAYMENT PROGRAM APPLICATION

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 will not be eligible* for the program.

II. APPLICANTION 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 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

Income: Household Monthly Income _____ Number of Persons in Household_____

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 (844) 421-7050.

AUTHORIZATION: I authorize insurance companies, employers, providers of health care services, enrollment workers, 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. I understand that it is my responsibility to immediately notify my Enrollment Worker and CDPH of changes to my policy including: change in billing address; or enrolled in employer-based health insurance, or 100% Extra Help/Full Low Income Subsidy (LIS) or Full-Scope (free) Medi-Cal.

_____ _____

Applicant's Signature Date

INSURANCE ASSISTANCE CONSENT FORM

Consent to Participate and Consent to Release Personal and Medical Information

The California Department of Public Health (CDPH), Insurance Assistance Programs provide health insurance premium payment assistance to low-income individuals living with human immunodeficiency virus (HIV). Individuals applying for these 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 modified adjusted gross income that does not exceed 500 percent of the federal poverty level per year based on family size and household income.

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 a CDPH insurance assistance 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 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, CDPH contractors associated with the administration of the program, 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, COBRA administrators, health insurance companies, employers and employer administered health insurance plans, health care professionals who provide services to me, CDPH contractors associated with the administration of the program and other governmental or public agencies as necessary to determine my eligibility for 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		

*Please disregard enrollment worker section if client completes this application.