N.C. Department of Health and Human Services
Division of Public Health
Purchase of Medical Care Services
1907 Mail Service Center
Raleigh, NC 27699-1900

DHHS 3014/3056

Authorization Request/ Financial Eligibility

1. Last Name First Name MI

2. Current POMCS/ADAP Case Number

3. Social Security Number

4. Date of Birth (MM/DD/YYYY)

5. Program **ADAP**

6. Diagnosis Code **B20**

7. Application Type/Requested Dates of Service
- ☐ 1. New Application (Immediate Coverage)
- ☐ 2. Summer Renewal (October 1 to March 31)
- ☐ 3. Winter Renewal (April 1 to September 30)
- ☐ 4. New Application (Delay Start Date)

Requested Start Date: _____

Explanation (Documentation Required) _____

_____

_____

8. ADAP Sub-program
- ☐ 1. APP (No Insurance)
- ☐ 2. SPAP (Medicare Part D)
- ☐ 3. ICAP (Qualified Health Plan Purchased on the Federal Marketplace)

9A. Gender ☐ 1. Male ☐ 2. Female ☐ 3. Transgender

9B. Transgender Subcategory
☐ 1. Male to Female ☐ 2. Female to Male ☐ 3. Unknown

10A. Race ☐ 1. White ☐ 2. Black or African American ☐ 3. American Indian or Alaska Native ☐ 4. Asian ☐ 5. Native Hawaiian/Pacific Islander ☐ 6. Unknown ☐ 7. More Than One Race

10B. Race Subcategory
Asian: ☐ 1. Asian Indian ☐ 2. Chinese ☐ 3. Filipino ☐ 4. Japanese ☐ 5. Korean ☐ 6. Vietnamese ☐ 7. Other Asian

NH/PI: ☐ 1. Native Hawaiian ☐ 2. Guamanian or Chamorro ☐ 3. Samoan ☐ 4. Other Pacific Islander

11A. Ethnicity ☐ 1. Hispanic/Latino(a) ☐ 2. Non-Hispanic

11B. Ethnicity Subcategory
Hispanic: ☐ 1. Mexican, Mexican American, Chicano/a ☐ 2. Puerto Rican ☐ 3. Cuban ☐ 4. Other Hispanic, Latino/a or Spanish Origin

12. Language
- ☐ 1. English ☐ 2. Spanish
- ☐ 3. Other (Specify) _____

13. Incarcerated? ☐ 1. Yes ☐ 2. No

Local County Jail (Name) _____

14. N.C. Resident? ☐ 1. Yes ☐ 2. No

15. Applicant's County of Residence

16. Applicant's County Code

17. Applicant's Street Address
(Must match documentation of residence)

18. City State Zip Code

19. Applicant's Telephone Number (Include Area Code)
(Home/Cell) (Work)

20. Applicant's Mailing Address
☐ Check if the address is the same as above

Care of, if applicable

Address (Street or RFD)

City State Zip Code

21. First HIV/AIDS Diagnosis Date
(Include Month and Year, If Known)
- ☐ 1. Month (MM) ____
- ☐ 2. Year (YYYY) _____
- ☐ 3. Unknown

22. HIV/AIDS Status
- ☐ 1. HIV Positive–Not AIDS
- ☐ 2. HIV Positive–CDC defined AIDS
- ☐ 3. HIV Positive–AIDS Status Unknown

23. Has the applicant used tobacco products four or more times per week in the past six months?
☐ 1. Yes ☐ 2. No

24. Lab Values (Lab values must match the documentation provided with this application.)

CD4 Count (If available)	Viral Load (Required)
Date (MM/DD/YYYY)	Date (MM/DD/YYYY)

Name: _____ Date of Birth: _____

25. **Countable** Family Members (Including Applicant)
Number of Adults _____
Number of Children _____
Total Number _____

INCOME FORMULAS: Regular **(R)**—Continuously employed wage earners list income for the 12 months before the date of application or the requested date of coverage, whichever is earlier. Unemployment **(U)**—Wage earners unemployed at the time of application or for 30 consecutive days during the previous 12 months list income for 6 months before and after the date of application or the requested date of coverage whichever is earlier. **Must report Gross and Net Income.**

26. Complete for All Countable Family Members Name	Relationship to Patient	Income Formula (R or U)	List all Employers or Sources of Income/Reason for None for **12 Month Period**	Dates From	Dates To	**Gross Income**	**Income After Taxes**

27. Explain Means of Support: (Check each item that is applicable)

- ☐ Community Support
- ☐ Family Support
- ☐ Food Stamps/EBT
- ☐ Housing Assistance
- ☐ Medical Assistance
- ☐ Migrant Worker
- ☐ Transportation Assistance
- ☐ Utility Assistance
- ☐ Other, specify: _____
- ☐ Unemployed, specify dates: _____

28. **Annual Gross Income** . . . . . _____

Federal, State & Social Security Tax . . . . . _____

Total Income After Taxes (Difference Between Both Lines) . . . . . _____

Medical expenses paid or incurred during past 12 months not covered by a third party nor requested for program coverage . . . . . _____

Other deductions: (Specify, deduction(s)) . . . . . _____

Total Deductions . . . . . _____

Annual Net Income . . . . . _____

29. Has the applicant applied for: (Check either Yes or No to each item)

Medicaid: ☐ Yes ☐ No
Medicare: ☐ Yes ☐ No ☐ NA: Automatically Enrolled
Enrolled in Medicare Part D: ☐ Yes ☐ No (If yes, complete box 31)
SS LIS Application: ☐ Yes ☐ No ☐ NA
If yes for LIS, provide date: (MM/DD/YYYY)

30. PRIVATE INSURANCE: Provide complete insurance information and copies of insurance cards **for all countable family members.**

Not Applicable ☐
Insurance Company/Plan Name:
RXBIN:
RXPCN:
RXGRP:
Policyholder:
Is patient covered? ☐ Yes ☐ No
Does insurance have a cap? ☐ Yes ☐ No
If yes, provide amount and submit documentation: $

31. MEDICARE PART D COVERAGE: Provide complete information.

Not Applicable ☐
Insurance Company/Plan Name:
RXBIN:
RXPCN:
RXGRP:
Policyholder:

32. HOUSING ARRANGEMENT
☐ Stable/Permanent ☐ Temporary ☐ Unstable

33. Interviewer's Information (Requesting Office)

Interviewer's Name:
Agency:
Address:
County Code:
Phone Number:

34. Alternate Clinical/Professional Contact

Last Name First Name MI

Phone Number:

35. Clinician's Information

Clinician's Name:
Agency:
License #:
Address:
County Code:
Phone Number:

I hereby certify that I have read or the interviewer has read to me the terms and conditions described within and that I agree to comply with them. I also certify that I have been provided an opportunity to ask the interviewer questions about these terms and conditions and that I understand the answers I was given.

36. **Applicant's Signature** **Relationship to Applicant** **Current Date** (MM/DD/YYYY)

I certify that I have explained the terms and conditions contained within and have witnessed his/her signature.

37. **Interviewer's Signature** **Current Date** (MM/DD/YYYY)

I certify that the above named individual is HIV Positive and has prescriptions for a medication listed on the current N.C. ADAP Formulary.

38. **Clinician's Signature** **Current Date** (MM/DD/YYYY)

Mail (do not Fax) this application and documentation to:

DHHS, Division of Public Health, Purchase of Medical Care Services, 1907 Mail Service Center, Raleigh, NC 27699-1900

TERMS AND CONDITIONS FOR APPLICANT

Must be signed and dated or the application will be pended.

I agree to notify the interviewer within 30 days about any changes in my address, financial resources, expenses, family situation, or health insurance coverage that might affect my eligibility for Department payment programs. I certify that the information I have provided is a true and complete statement of facts according to my best knowledge and belief. I understand that information provided may be checked by a state reviewer, and I agree to provide the financial records required to carry out this investigation. I also understand that my employer may be asked to verify information concerning my income.

I assign insurance benefits to the Department. I agree to repay the Department any money I receive from insurance or liability settlements for services or appliances which the Department purchased for me. I understand that such payments should be made to the Department within 45 days of the date that I receive them and that the amount paid to the Department should not exceed the amount the Department paid the provider. I further agree that failure to repay assigned insurance benefits to the Department is a reason for denial of future service requests to the Department until such amounts have been repaid.

I understand that my eligibility for Medicaid will be checked. I hereby authorize and agree to a free exchange of information between the Division of Medical Assistance and the Department of Health and Human Services relating to financial information and the amount of services provided by either program.

I hereby authorize the interviewer and service providers to release to the Department and its affiliate programs the information provided on this form and also the medical records of the patient which pertain to medical services or appliances for which reimbursement is being sought from the Department.

I also authorize release of this information to the county health department where the patient resides and/or receives services. I also authorize release of the information on this form to all health departments, hospitals, and service providers in North Carolina. These disclosures shall be made for purposes of determining the patient's eligibility for Department payment programs and for conducting program evaluation.

I also authorize release of enrollment, eligibility and utilization records to my physicians, my case manager, other medical providers, the contracted pharmacy, Pharmacy Benefits Managers, third party administrators, health insurers or other service providers to facilitate program services.

I voluntarily give my consent to the terms of this release. My consent shall be valid for a period of one year. I further understand that I may revoke my consent at any time. Such revocation does not affect the validity of my consent for information disclosed prior to the revocation.

I understand that I may appeal the denial of this financial eligibility application. Information on how to appeal the denial can be obtained by writing to Purchase of Medical Care Services, 1907 Mail Service Center, Raleigh NC 27699-1900. I understand that payment by the Department for health care provided to me is dependent upon me meeting all financial and medical requirements, timely submission of authorization requests and claims, and the availability of funds.

North Carolina County Codes (see Boxes 16, 33, 35)*

001 ALAMANCE	021 CHOWAN	041 GUILFORD	061 MITCHELL	081 RUTHERFORD
002 ALEXANDER	022 CLAY	042 HALIFAX	062 MONTGOMERY	082 SAMPSON
003 ALLEGHANY	023 CLEVELAND	043 HARNETT	063 MOORE	083 SCOTLAND
004 ANSON	024 COLUMBUS	044 HAYWOOD	064 NASH	084 STANLY
005 ASHE	025 CRAVEN	045 HENDERSON	065 NEW HANOVER	085 STOKES
006 AVERY	026 CUMBERLAND	046 HERTFORD	066 NORTHAMPTON	086 SURRY
007 BEAUFORT	027 CURRITUCK	047 HOKE	067 ONSLOW	087 SWAIN
008 BERTIE	028 DARE	048 HYDE	068 ORANGE	088 TRANSYLVANIA
009 BLADEN	029 DAVIDSON	049 IREDELL	069 PAMLICO	089 TYRRELL
010 BRUNSWICK	030 DAVIE	050 JACKSON	070 PASQUOTANK	090 UNION
011 BUNCOMBE	031 DUPLIN	051 JOHNSTON	071 PENDER	091 VANCE
012 BURKE	032 DURHAM	052 JONES	072 PERQUIMANS	092 WAKE
013 CABARRUS	033 EDGECOMBE	053 LEE	073 PERSON	093 WARREN
014 CALDWELL	034 FORSYTH	054 LENOIR	074 PITT	094 WASHINGTON
015 CAMDEN	035 FRANKLIN	055 LINCOLN	075 POLK	095 WATAUGA
016 CARTERET	036 GASTON	056 MACON	076 RANDOLPH	096 WAYNE
017 CASWELL	037 GATES	057 MADISON	077 RICHMOND	097 WILKES
018 CATAWBA	038 GRAHAM	058 MARTIN	078 ROBESON	098 WILSON
019 CHATHAM	039 GRANVILLE	059 MCDOWELL	079 ROCKINGHAM	099 YADKIN
020 CHEROKEE	040 GREENE	060 MECKLENBURG	080 ROWAN	100 YANCEY

* Interviewers and clinicians located outside of North Carolina should use County Code 000.

Instructions for Authorization Request/Financial Eligibility

All fields must be completed or application will be pended.

PURPOSE: This form is used to request authorization for the ADAP program and to collect financial information required for determination of ADAP eligibility. Once determined, eligibility extends for nine months. A new form is required when changes in countable family members and/or income occur. Processing time is reduced when this form is legible. If requested, additional information must be received within six months. Incomplete forms will be pended.

INSTRUCTIONS FOR COMPLETING CERTAIN ITEMS ON THIS FORM:

2. Current ADAP clients must provide their POMCS/ADAP Case Number. New applicants should leave this blank. Applicants that were previously enrolled in ADAP should provide their original POMCS/ADAP Case Number if available.
3. Leave Social Security Number blank if applicants do not have one.
7. If a delayed start date is requested provide an explanation such as "private insurance ends at the end of the month," or "applicant will be released from prison on . . . ." See the ADAP Application Manual for more information.
8. Indicate the subprogram that existing clients are served by or choose a subprogram for new applicants based on their insurance status.

9B. If Transgender is chosen, HRSA requires applicants to choose a Transgender Subcategory.

10B. If Asian or Native Hawaiian or Pacific Islander is chosen, HRSA requires applicants to choose a Race Subcategory.

11B. If Hispanic/Latino is chosen, HRSA requires applicants to choose an Ethnicity Subcategory.

13. If the applicant is incarcerated; check yes, provide the name of the county jail and provide the jail's address in boxes 17 and 18.

**NOTE: Patients incarcerated in state or federal prisons are not eligible for ADAP.

17. The address provided in boxes 17 and 18 must match the documentation of North Carolina residence. Correspondence from ADAP and POMCS will go to this address unless an alternate mailing address is provided in box 20.
20. If applicant/client provides an alternate mailing address — all correspondence will be sent to that address.
24. Documentation of CD4 Count and Viral Load must be dated within 12 months of the date this form was signed.
25. **Countable Family Members** are related to the applicant by blood, marriage or adoption, live in the same household and share a financial responsibility. The applicant must be included in the count.
27. Explain how the applicant is meeting basic needs. If the No/Low Income Sheet is also being submitted, be sure the explanation provided matches box 27.
28. **Deductible Medical Expenses** (under Annual Gross Income) are those paid or incurred by a countable family member during the 12 months prior to the earliest date of service. Expenses paid for by another party or requested for coverage by a program cannot be used as deductions. Medical expense deductions that exceed $3,000 must be documented in full. Eligibility decisions are based on gross income unless a waiting list or reduced eligibility has been implemented.
29. Medicare, Medicaid status and, if applicable, Social Security eligibility information for a low income subsidy are required for all applicants. If yes is checked for SS LIS Application, the date must be included. If automatically eligible for LIS, check "NA."
30. If the applicant has a private insurance plan, please provide information from the applicant's insurance card and provide a copy.
31. If the applicant has a Medicare Part D plan please provide information from the applicant's Part D card and provide a copy.
36. The applicant is required to read the terms and conditions on Page 3 and sign in box 36.
37. The interviewer is required to read the terms and conditions on Page 3 and sign in box 37.
38. The clinician must certify that the applicant is HIV Positive and has been prescribed a medication on the ADAP formulary by signing in box 38.