Connecticut Department of Public Health
AIDS Drug Assistance Program (CADAP)

Eligibility Criteria

To be eligible for CADAP, individuals must:

- be HIV positive,
- reside in Connecticut, and
- have a family household income that is equal to or less than 400% of the Federal Poverty Guidelines.

Eligibility Determination

An individual who wants to apply for CADAP must complete and submit a CADAP application. Applications may be completed by the applicant or the applicant's HIV case manager, social worker, clinician, or anyone else working in an official capacity on the applicant's behalf.

Enrollment Method

You may return your completed enrollment application using one of the following methods:

- **By Fax:** 800-424-7642
- **By Mail:** State of CT Department of Public Health
  c/o Magellan Rx Management
  P.O. Box 13001
  Albany, NY 12212-3001
- **By Email:** CTDPHMRxEnroll@magellanhealth.com
- **Complete the application online at:** https://ct.mrxenroll.magellanrx.com

APPLICANT INFORMATION

ARE YOU COMPLETING THIS APPLICATION: ☐ **FOR YOURSELF** ☐ **OR ON BEHALF OF SOMEONE ELSE**

LAST NAME: **FIRST NAME:**

CADAP ID NUMBER: **DATE OF BIRTH:** / /

HOME PHONE: – – **CELL PHONE:** – –

SOCIAL SECURITY NUMBER:

CONNECTICUT RESIDENTIAL STREET ADDRESS ☐ **DO NOT SEND MAIL HERE**

STREET ADDRESS:

STREET ADDRESS (LINE 2):

CITY: **STATE:** **ZIP CODE:**

PREFERRED MAILING ADDRESS (MUST BE CONNECTICUT BASED)

ADDRESS:

ADDRESS (LINE 2):

CITY: **STATE:** **ZIP CODE:**

ONE OR MORE OF THE FOLLOWING MUST BE INCLUDED AS PROOF OF CONNECTICUT RESIDENCY:

- Any documents from a government agency (Medicare, Social Security, Veteran's Affairs, SNAP-Food stamps)
- Mortgage statement or lease agreement (most recent)
- Utility bills (electric, water, gas, phone, cable, etc.) within last 30 days
- Photocopy of valid, unexpired CT Driver's License or CT Non-Driver ID Card
- Photocopy of valid, unexpired CT Department of Motor Vehicles-issued Identification card
- U.S. Immigration Card (current)
- Community Service/Ryan White Case Manager Agency Residency Attestation of Homelessness dated within 30 days (use Attestation Form located at the end of this application)
- Property tax bill

Note: All proof of residency must include the applicant's name and home address (no P.O. boxes).

GENDER:

SEX AT BIRTH

☐ Male ☐ Female

CURRENT GENDER

☐ Male ☐ Female ☐ Transgender (Male to Female) ☐ Transgender (Female to Male)
☐ Transgender (Other) ☐ Unknown

ETHNICITY:

☐ Non-Hispanic ☐ Another Hispanic/Latino/a or Spanish Origin ☐ Mexican/Mexican American/Chicano/a
☐ Puerto Rican ☐ Cuban

RACE/HERITAGE:

☐ American Indian or Alaska Native (specify tribal affiliation) _____
☐ Asian – Indian ☐ Asian – Chinese ☐ Asian – Filipino ☐ Asian – Japanese
☐ Asian – Korean ☐ Asian – Vietnamese ☐ Asian – Other, specify: _____
☐ White ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander
☐ Other, specify: _____

PREFERRED SPOKEN LANGUAGE:

☐ Albanian ☐ American Sign Language ☐ Bengali ☐ Chinese
☐ Chinese, Mandarin ☐ English ☐ French Creole (e.g., Haitian) ☐ Greek
☐ Polish ☐ Portuguese ☐ Romanian ☐ Russian
☐ Spanish ☐ Telugu ☐ Vietnamese
☐ Other Language, specify: _____

MARITAL/PARTNER STATUS:

☐ Married ☐ Divorced ☐ Widowed ☐ Separated
☐ Never married ☐ Member of an unmarried couple ☐ Other, specify: _____

PREGNANCY STATUS:

Have you been pregnant within the last six months? ☐ Yes ☐ No

OTHER HEALTH INSURANCE & PREMIUM ASSISTANCE

HEALTH INSURANCE COVERAGE INFORMATION

Do you currently have health insurance? ☐ Yes ☐ No

If yes, does it cover prescription drugs? ☐ Yes ☐ No

If yes, check all that apply:

☐ Health Insurance through an employer (individual or group)

☐ COBRA or similar continuation coverage

☐ Self-purchased (individual) ☐ Self-purchased ACA/Marketplace

☐ Medicare A/B ☐ Medicare D

☐ VA Military Plan ☐ Other _____

If you do not have health insurance, please check the reason why:

☐ Cannot afford cost of premiums ☐ I do not qualify for insurance

☐ Other reason _____

PLEASE INCLUDE A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD WITH THIS APPLICATION.

**IF YOUR INSURANCE POLICY IS TERMINATED,
PLEASE NOTIFY US AS SOON AS POSSIBLE AND SUBMIT YOUR TERMINATION LETTER.**

PREMIUM ASSISTANCE

We can help pay your insurance premium to your employer, Medicare, or the health exchange. Do you need help paying for your insurance premium? If you check yes, you will be applying for the Connecticut Insurance Premium Assistance Program.*	☐ Yes	☐ No

***PLEASE INCLUDE A COPY OF THE INSURANCE PREMIUM INVOICE/STATEMENT WITH THIS APPLICATION.**

***IF EMPLOYER-SPONSERED INSURANCE PREMIUM ASSISTANCE IS NEEDED, INCLUDE NAME OF HR REPRESENTATIVE AND PHONE NUMBER, IF AVAILABLE.**

Employer Contact Name (IF APPLICABLE):

Phone Number:

– –

I hereby authorize the Connecticut Department of Public Health to share my information with its contractors for the purpose of coordinating my insurance benefits. I acknowledge that as a condition of this premium assistance, I must fill my medications using an in-network pharmacy and that the Department must be billed as secondary payer. I acknowledge that failure to adhere to the aforementioned stipulations may result in the Department's cancellation of my premium assistance and may request reimbursement of the expenses incurred.

I understand that the Department of Public Health will make every effort to protect my health information. The Department's contractors will work closely with the individual(s) listed above, if named, to coordinate my insurance benefits. In the event that the Department or its contractors disclose my information without my permission, I will be notified in writing. I agree to indemnify and hold harmless the Department and its contractors in the event my health information is disclosed through no fault of the Department.

☐ Yes ☐ No

IF YOU HAVE A MEDICARE PLAN, ONLY MEDICARE PART D AND MEDICARE ADVANTAGE PLANS QUALIFY. MEDICARE SUPPLEMENTAL PLANS ARE NOT ELIGIBLE FOR PREMIUM ASSISTANCE

HOUSEHOLD INCOME

INCOME INFORMATION

Financial eligibility is determined by your family household size and total income from all sources.

Household income includes that of the following individuals with whom the applicant lives: spouse, parents if the applicant is under 18, and children under the age of 18.

Current family income: _____ ☐ Annual ☐ Monthly ☐ Other, specify_____

☐ Zero income, living off savings or others ***Complete the zero income affidavit.**

If your household does not know you are applying for this program and do not feel comfortable providing their income information, please check this box: ☐

Please list all members of the household including relationship and their monthly income.

If necessary, attach a separate listing for additional family members.

Full Name	Date of Birth	Relationship	Monthly Income	Social Security Number

INCOME SOURCES: (CHECK ALL THAT APPLY AND ATTACH DOCUMENTATION)

☐ Employed with Paystubs ☐ Full-time ☐ Part-time

☐ Employed without Paystubs ****Complete self-employment form found here:*** https://ctdph.magellanrx.com/member/

☐ Self-Employed ****Attach last year's income tax return and all tax forms & schedules, and complete the Self-Employment form:*** https://ctdph.magellanrx.com/member/

☐ SSA (Social Security Retirement Benefit)

☐ SSI (Supplemental Security Income)

☐ SSD (Social Security Disability) ****Attach award letter/bank statement with direct deposit***

☐ Alimony/Child Support ☐ Workers' Compensation ☐ Veterans' Benefits

☐ Unemployment Compensation ☐ Pension ☐ Public Assistance

☐ Interest/Dividends/Royalties ☐ Rental Property

HIV ATTESTATION

CONFIRMATION OF HIV DIAGNOSIS BY A LICENSED CLINICIAN

Note: The following section must be completed by a physician, physician assistant, or advanced practice registered nurse. I certify that the medical information provided below is true and accurate to the best of my knowledge. I certify that I will and/or have prescribed medications to treat HIV and/or HIV disease related condition(s) for the below patient.

CLIENT INFORMATION

LAST NAME: **FIRST NAME:**

ID NUMBER: **DATE OF BIRTH:** – –

The above applicant/patient's current clinical status/diagnosis is:

☐ HIV +, not AIDS ☐ HIV +, AIDS status unknown ☐ CDC-Defined AIDS

Please provide the most recent results and test dates within the last 12 months for the above patient:

CD4 COUNT: **TEST DATE:** **HIV VIRAL LOAD:** **TEST DATE:**

Physician/Physician Assistant/APRN Printed Name ***State License Number (required)***

Physician/Physician Assistant/APRN Signature ***Signature Date***

Office Address ***Telephone No.***

Note: Medical information must be completed and signed by a physician, physician assistant, or an advanced practice registered nurse for all new CADAP applicants and must accompany your completed application or recertification application to continue CADAP eligibility.

PRIMARY CARE PHYSICIAN - ENROLLEE MUST COMPLETE THIS SECTION

PRIMARY CARE PHYSICIAN LAST NAME: **PRIMARY CARE PHYSICIAN FIRST NAME:**

PRIMARY CARE PHYSICIAN PHONE NUMBER: – – **PRIMARY CARE PHYSICIAN FAX:** – –

STREET ADDRESS:

CITY: **STATE:** **ZIP CODE:**

AUTHORIZED REPRESENTATIVES

CASE MANAGER

Do you have a Case Manager? ☐ Yes ☐ No

CASE MANAGER LAST NAME: **CASE MANAGER FIRST NAME:**

CASE MANAGER PHONE NUMBER: – – **CASE MANAGER E-MAIL ADDRESS:**

FACILITY/AGENCY NAME:

STREET ADDRESS:

CITY: **STATE:** **ZIP CODE:**

LEGAL GUARDIAN

Are you a Legal Guardian for the applicant? ☐ Yes ☐ No

LEGAL GUARDIAN LAST NAME: **LEGAL GUARDIAN FIRST NAME:**

OTHER AUTHORIZED REPRESENTATIVES

Do you have another individual that can speak on your behalf? ☐ Yes ☐ No

Does this person have Power of Attorney? ☐ Yes ☐ No

FULL NAME AND TITLE OF AGENCY:

STREET ADDRESS:

CITY: **STATE:** **ZIP CODE:**

PHONE NUMBER: – – **FAX NUMBER:** – –

E-MAIL ADDRESS:

Magellan Rx MANAGEMENT

SIGNATURE SECTION

- ☐ I understand this application and affirm that the answers provided are true to the best of my knowledge.
- ☐ I understand that the information on this application is subject to verification by the State. I may be subject to penalties for false statement as specified in Section 53a-157b of the Connecticut General Statute and to penalties for larceny as specified in Sections 53a-122, 53a-123, and 53a-124. I also may be subject to penalties for perjury under Federal Law.
- ☐ I consent to Magellan and the Department of Public Health managing my prescription drug benefits subject to all federal and state regulations.
- ☐ I agree to notify the Department of Public Health within 10 business days if I return to work or if there is any change in address, private insurance information, termination, and/or premium amounts and household income, assets, or family size.
- ☐ I understand that by receiving medical assistance, I allow the State to recover the cost of my prescription claims, which may have been covered by other insurance, directly from the insurance company.
- ☐ I understand that if I am not satisfied with the actions taken by the Department of Public Health concerning my eligibility of CADAP, I have the right to request a hearing within 10 calendar days from the date of notice of action by writing to:
  Office of Legal Counsel, Regulation, and Administrative Hearings
  State of Connecticut Department of Public Health
  410 Capitol Ave
  Hartford, Connecticut 06103.
- ☐ By designating a Case Manager, Legal Guardian, Authorized Representative, or Power of Attorney, you are authorizing Magellan to communicate with that person about all matters concerning your application, including, but not limited to matters concerning your eligibility for the program and your health status. If you wish to revoke this authorization, you may do so by notifying Magellan, in writing, of the revocation. No revocation will be effective until Magellan receives the written revocation.
- ☐ I have received a copy of the Department's Notice of Privacy Practices (Found here: https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/Laboratory/NPP-10-17-18.pdf)

Signature of Applicant	***Date***
Signature of Authorized Representative	***Date***

APPLICATION CHECKLIST

- ☐ Attach proof of your Connecticut residence.
- ☐ Attach proof of your current income from all sources.
- ☐ Attach a copy of your completed Access Health CT application or Access Health CT denial letter from within the past 12 months, if applicable.
- ☐ Include a copy of your health insurance card(s) (front and back), if applicable.
- ☐ Completely fill out all sections of your CADAP Application.
- ☐ Have your Medical Provider fill out the Section IV Medical Information page with current, updated lab information and upload to MRx Enroll or fax to 1-800-424-7642.
- ☐ Sign and date the CADAP Application.
- ☐ If you have zero income, please download and complete the zero income affidavit section at the end of this application or download the form from the CADAP website: https://ctdph.magellanrx.com/member/.
- ☐ If you are self-employed or do not receive paystubs, please complete the Self-Employment Form on the CADAP website: https://ctdph.magellanrx.com/member/

Individuals requiring assistance to complete this application, including those with visual impairment, can receive assistance by contacting their Medical Case Manager, by calling CADAP at 1-800-424-3310, or by calling our Affirmative Action Division ADA Coordinator at 1-860-424-5040. Deaf and hearing-impaired individuals may use a TDD/TTY by calling 1-800-842-4524. Services are available without regard to race, sexual orientation, color, creed, sex, age, disability, national origin, ancestry, language barriers, political or religious beliefs. Note: It is important to know that because continued funding is uncertain, the scope of services and conditions of participations in CADAP and/or premium assistance may change in the future.

CONNECTICUT RESIDENCY ATTESTATION

Community Service Agency Representative/Case Manager/Health Care Worker Residency Attestation

For agency use only: May only be completed by a Representative/Case Manager/Health Care Worker

- ☐ I affirm I have visited the client at the above address identified in the Client Information section.
- ☐ I affirm the client is homeless.

Staff Member Printed Name	***Name of Provider Agency***
Staff Member Signature	***Date***

ZERO INCOME AFFIDAVIT

I, _____, have requested services through the Connecticut AIDS Drug Assistance Program, which is funded through the Health Resources and Services Administration (HRSA), which requires verification of total household income.

* Income includes, but is not limited to:

- Gross wages, salaries, overtime pay, commission, fees, tips, and bonuses
- Income from operation of a business or from rental or real property
- Interest, dividends, and other income of any kind for real personal property
- Periodic payments received from Social Security, annuities, insurance policies, retirement funds, pensions, disability or death benefits, and other similar types of period receipts
- Lump sum payment(s) for the delay start of a periodic payment such as SSI or SSDI retroactive payments
- Payments in lieu of earnings, such as unemployment and disability compensation, worker's compensation, and severance pay
- Alimony and/or child support payments
- Regular pay, special pay, and allowances of a head of household or spouse who is a member of the Forces (whether or not living in the dwelling)

☐ I have stated during the verification process that I have no income at this time.

I have not received income since _____.

I do not expect to receive income until _____.

I have applied for (other financial assistance) on _____ (date).

*__Note__: It is unlawful to provide false information to the government when applying for federal public benefits programs per the Program Fraud Civil Remedies Act of 1986, 31 U.S.C. SS 3809. I certify that the above information is true and correct. I also understand that it is my responsibility to report all changes to my household composition or income in writing within ten business days of such change.

_____ _____

Signature ***Date***

_____ _____

Witness ***Date***