Connecticut Department of Public Health, AIDS Drug Assistance Program

CADAP Recertification Form

Need help? Call: 1-800-424-3310

Return completed forms to:

Fax: 1-800-424-7642

Mail: State of CT Department of Public Health, PO Box 13001, Albany NY 12212-3001

Email: ctdphmrxenroll@magellanhealth.com

Website: https://ct.mrxenroll.magellanrx.com

ONLY COMPLETE THIS FORM IF YOU ARE ELIGIBLE FOR 6-MONTH RECERTIFICATION. IF YOU ARE UNSURE OF WHICH ENROLLMENT FORM TO COMPLETE, PLEASE CALL MAGELLAN RX MANAGEMENT AT **1-800-424-3310.**

Please complete and sign this notice in order to continue your CADAP coverage. You may return your notice through one of the following recertification methods listed below.

Recertification Criteria

To continue to be eligible for CADAP, individuals must:

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

Recertification Determination

An individual who wants to recertify and continue coverage with CADAP must complete and submit this Recertification Form. Recertifications 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. *Any changes in information will require proof of change. You must attach proof of change when submitting this recertification form. Failure to include this information will cause your recertification to be delayed and may result in termination of benefits.*

Recertification Method

To complete recertification, use one the following methods:

- Mail the completed form to:

  State of CT Department of Public Health
  PO Box 13001
  Albany, NY 12212-3001
- Complete the form online at https://ct.mrxenroll.magellanrx.com
- Email completed form to ctdphmrxenroll@magellanhealth.com
- Fax completed form to 1-800-424-7642

 Revision Date: 11/01/2021

Magellan Medicaid Administration, part of the Magellan Rx Management division of Magellan Health, Inc.

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CADAP ID Number:

C	T							

FULL NAME

First Name:

Last Name:

CONTACT INFORMATION

Home Phone: ___ – ___ – ____

Cell Phone: ___ – ___ – ____

RESIDENTIAL ADDRESS

IF YOUR ADDRESS HAS CHANGED, PLEASE ATTACH PROOF OF NEW ADDRESS

Street Address:

City:

State: **Zip Code:**

☐ Do not send mail to this address

MAILING ADDRESS

IF YOUR ADDRESS HAS CHANGED, PLEASE ATTACH PROOF OF NEW ADDRESS

Street Address:

City:

State: **Zip Code:**

☐ Do not send mail to this address

(Form continued on next page.)

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C	T							

HOUSEHOLD SIZE AND INCOME

IF YOUR INCOME HAS CHANGED, PLEASE ATTACH PROOF OF NEW INCOME. (If your income has changed and you have no income, please contact the Magellan enrollment center to request a zero income affidavit.)

Household Size: _____

Annual Income: _____

Household Members' Information (include names, dates of birth, and relationship):

1. _____
2. _____
3. _____
4. _____
5. _____

HEALTH INSURANCE INFORMATION

FOR ANY CHANGES, PLEASE COPY AND ATTACH THE FRONT AND BACK OF ID CARDS

Insurance Name: _____

ID Number: _____

Group Number: _____

Premium Payments: Do you need assistance with paying for your insurance premiums?

We can help pay your insurance premium to your employer, Medicare, or the health exchange. **Do you need help with your insurance premium?** ☐ Yes* ☐ No

* If you check **yes**, you will be applying for the Connecticut Insurance Premium Assistance Program.

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

_____ _____

Signature **Date**

I understand this recertification form and affirm that the answers provided are true and correct to the best of my knowledge.

