ACA Assessment Tool

Date: _____ CIS#:_____ Agency ID#:_____

Agency Name: _____

Medical Case Manager (MCM) Name: _____

MCM Phone#:_____ MCM email: _____

Client's zip code: _____

Client's income: (individual income): _____

(INDIVIDUAL Federal Poverty Level %): _____

(household size): _____

(household income): _____

(HOUSEHOLD Federal Poverty Level %): _____

(MAGI* income – per ACA Navigator / CAC only): _____

**Modified Adjusted Gross Income*

Did client provide a copy of their IRS tax return: YES _____ NO _____

Did client receive a tax return refund: YES _____ NO _____

Client's preferred hospital: _____

Client's preferred pharmacy: _____

Name of Primary Care Provider (PCP): _____
(last name/first name)

PCP phone#: _____

How often does client see PCP? _____

Name of HIV Provider: _____
(last name/first name)

HIV Provider phone#: _____

How often does client see HIV Provider (if any)? _____

ACA Assessment Tool

Does client have other chronic conditions (e.g., diabetes, high blood pressure, Hep B, Hep C, or mental health condition)? _____

Specialty condition #1:_____

Name of Specialist: _____
(last name/first name)

Specialist's phone#:_____

How often does client see Specialist (if any)? _____

List of ALL medications: _____

Would the client be willing to enroll in a plan that restricts where (a specific pharmacy chain) or how (mail order only) the client obtains his or her drugs? Yes _____ No _____

If NO, please explain: _____

Has client been hospitalized within the last 12 months? _____

Is client at risk of being hospitalized within the next 12 months? _____

Does the client expect to need surgery or another major procedure in the next year? ____

If YES, please explain: _____

How many times a year does the client visit an urgent care center or emergency room? _____

Name of ACA Navigator or Certified Application Counselor (CAC): _____

ACA Navigator or CAC Phone#: _____

Address: _____

_____

Date of Appointment: _____

Time of Appointment: _____

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--- SEE NEXT PAGE FOR ADDITIONAL INSTRUCTIONS FOR THE PART A MEDICAL CASE MANAGER, THE ACA NAVIGATOR, AND THE ACA CERTIFIED APPLICATION COUNSELOR ---

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FOR PART A MEDICAL CASE MANAGER:

ADAP ACA ASSISTANCE:

Is this client in ADAP and pre-approved for ACA Transition? Yes ____ No ____
If YES, complete the following:

Name of the ADAP-approved ACA Marketplace health plan(s) that appear(s) to meet this client's health care needs:

_____

FOR ACA NAVIGATOR OR CAC:

IMPORTANT NOTE: Please contact the Ryan White Part A Medical Case Manager listed on page 1 of this document to confirm this client's enrollment in the ACA.