Ryan White Program
Service Delivery Guidelines
Fiscal Year 2019
(Year 29)

Section XII –
General Revenue Short-Term
Access to Allowable Medications
(forms)

Miami-Dade County
Office of Management and Budget
Grants Coordination

GENERAL REVENUE (GR) SHORT-TERM MEDICATION* ASSISTANCE
THROUGH THE JMH SPECIALTY PHARMACY
for the Florida Department of Health and Ryan White Part A/MAI Programs in Miami-Dade County

Referral Start Date:_____ **Referral Stop Date*:**_____
Maximum referral length is two (2) months and is limited to GR Prescription Drug Formulary medications only.

REFERRAL FROM:

Part A/MAI Medical Case Manager Name: _____
Agency Name: _____
Phone: _____ **Fax:** _____

MEDICATIONS NEEDED:

List prescribed antiretroviral (ARV), opportunistic infection (OI), or other medication(s) needed per this referral: ***(limited to medications listed on the most current GR Prescription Drug Formulary only)***

_____

_____

Prescribing Practitioner Name: _____
Prescribing Practitioner Phone Number: _____

Special Instructions: _____

CLIENT INFORMATION: **CIS#:** _____

Name: _____ **DOB:** ___/___/___
Current SFAN# or Jackson "I01" Card #: _____
Social Security #: _____
Street Address: _____
City: _____ **Zip:** _____ **Phone Number:** _____

REASON FOR ASSISTANCE: *(Check one)*

- ☐ **HIV/AIDS Patient Care Core Eligibility approval pending confirmatory HIV+ test result (preliminary positive result available)**
- ☐ **ADAP initial enrollment process pending current (not more than 6 months old) CD4 and Viral Load lab test results**
- ☐ **ADAP re-enrollment is past due, client is out of medication, and client requires emergency supply of medications to ensure adherence to treatment regimen; client must begin the ADAP re-enrollment process**
- ☐ **Other reason not listed above why ADAP application/enrollment pending (specify reason: _____)**
- ☐ **Affordable Care Act (ACA) binder or monthly payment for premium delayed** ***(this option is not applicable for access to ARVs and OIs when the premiums would be paid by ADAP)***
- ☐ **Lost or stolen medications** ***(a police report, or incident report from a service provider, is required as backup)***
- ☐ **Test & Treat / Rapid Access client requires access to medications not otherwise available at this time**

I attest that all documentation provided with this referral is complete, accurate and true. I hereby authorize my medical case manager to provide this information to the Public Health Trust of Miami-Dade County / Jackson Health System for the purpose of obtaining short-term, emergency access to ARV, OI, or other medication(s) that are listed on the most current GR Prescription Drug Formulary while my enrollment into the ADAP program or ACA premium payment is pending, for medications that were properly documented as lost or stolen or to initiate treatment using the Test & Treat / Rapid Access protocol.

Client's Signature: _____ **Date:** ___/___/___

Required Documentation: **This referral must be accompanied by proof of HIV positive status, financial eligibility, and permanent Miami-Dade County residency. Please see the accompanying Client Eligibility Documentation Checklist for a list of acceptable eligibility documents and check the type of proof provided with this referral.**

Medical Case Management Supervisor's Signature: _____ **Date:** ___/___/___

☑State

Notice of Eligibility

Required Form

Date

Client's Name

Client's Address

It has been determined that you comply with the required eligibility requirements to receive allowable services from the Department of Health, Ryan White Program. Allowable services are based on availability, accessibility, funding and program qualifications for the AIDS Drug Assistance Program (ADAP), the ADAP Premium Plus (insurance), and the state Housing Opportunities for Persons with AIDS (HOPWA) specialty programs.

Your eligibility status for receiving allowable services from the HIV/AIDS Patient Care Programs is valid for 6 months from the date of this correspondence. You must have a new determination for eligibility no later than the expiration date provided below in order to continue services. You must advise the originating eligibility staff when there are changes which affect your eligibility status.

Household Size FPL Income

Other Programs (list all that apply)

Additional Comments

Re-determination Date Due No Later Than

Your signature below acknowledges your understanding of the following:

- I have received a copy and verbal explanation of this notice.
- I understand the requirements for receiving HIV/AIDS services.
- I verify that I have complied with all of the Rights and Responsibilities in the Application as verified by my signature on the application.

Client's signature:_____ Date:_____

Eligibility staff signature:_____ Date:_____

Eligibility Staff Name Phone

Address

Keep this notice of eligibility in a safe place. Bring this notice along with photo identification when meeting with an ADAP, ADAP Premium Plus, HOPWA, or case management representative about services.

DH8000-PHSPM-08/2014, Rule 64D-4.007(1)(a), F.A.C.

Client Eligibility Documentation Checklist
for Miami-Dade County Ryan White Program Services

This Checklist must accompany the Out of Network Referral (OON) form, Client Self-Referrals, or the "General Revenue (GR) Short-Term Medication* Assistance through the JMH Specialty Pharmacy" form. When using this Checklist for these referral purposes, please place a check mark next to the corresponding item in the lists below and attach the required documentation to the appropriate referral transmittal form.

(*NOTE: the "GR Short-Term Medication Assistance" provides emergency access to antiretroviral (ARV), opportunistic infection (OI), or other medications as listed on the most current General Revenue Prescription Drug Formulary only.)

Acceptable forms of client eligibility documentation are listed below. At least ONE (1) document from EACH group (medical, financial, residency) below MUST accompany each referral to support Ryan White Part A/MAI Program eligibility:

1) **MEDICAL ELIGIBILITY:** ***(HIV+ status)***
   - □ **4th generation HIV test result (with supplemental confirmatory tests)**
   - □ **HIV-1/ 2 Ab-Differentiation Immunoassay test result (e.g., Multispot® HIV-1/HIV-2 Rapid Test, Geenius HIV-1/2/ Supplemental Assay, etc.) (with supplemental confirmatory tests) [NOTE: The Geenius Assay replaced the Multispot test as of July 2016.]**
   - □ **HIV Western Blot**
   - □ **ELISA with Western Blot**
   - □ **Detectable viral load or culture result**
   - □ **Positive HIV viral culture or test result**
   - □ **Preliminary reactive (presumptive positive) HIV test result -- [USE ONLY for a Test & Treat / Rapid Access (TTRA) client who needs GR Short-term Medication Assistance when prescribed antiretroviral medication that is not available through the TTRA protocol]**

1a) Acceptable for Out of Network Clients ONLY: ***(NOT for use with GR Short-Term Medication Assistance)***
   - □ **Clear Health Alliance Medicaid card**

2) **FINANCIAL ELIGIBILITY:** ***[Gross household income not to exceed 400% of the Federal Poverty Level (FPL) for Core Medical Services; FPL may vary for Support Services. See below for details.]*****
   - □ **Paycheck stubs for the most current two (2) pay periods**
   - □ **SSI, SSDI, SSA, TANF checks or benefit/award letters/ other public assistance checks**
   - □ **HOPWA/Section 8 Rental Assistance Statement**
   - □ **Veterans Administration (VA) benefits statement/award letter**
   - □ **Other Letters of Notification of Benefits [e.g., Private Disability, Retirement/Pension, Workers Compensation Statement, Medicaid, Medicare, Low Income Subsidy, Women, Infants and Children (WIC) program, etc.]**
   - □ **Current Internal Revenue (IRS) W-2, Wage and Tax Statement form**
   - □ **Current & signed Individual or Business Tax Return forms**
   - □ **Third Party Query Procedure (TPQY) screenings for verifying SSA/SSI benefit information**
   - □ **A zero income letter from a shelter or residential treatment facility located in Miami-Dade County**
   - □ **Income from rental property**
   - □ **Child support or court order check**
   - □ **Head of Household (HOH) letter detailing client's relationship to the HOH and the level of financial assistance provided to the client**
   - □ **Statement of No Income and Local Residence Form (for clients up to 25 years of age, where applicable)**
   - □ **"Correction Health Services Referral" form from Jackson Health System's Jail Linkage Program if signed and dated by client and referring party; form is acceptable for the first six months after enrollment in Part A, only once client is released from jail**

2a) Acceptable for <u>Out of Network Clients ONLY</u>: *(NOT for use with GR Short-Term Medication Assistance)*

- □ **Clear Health Alliance Medicaid card**

3) <u>RESIDENCY ELIGIBILITY:</u> *(permanent residency in Miami-Dade County residency/physical living address)*

- □ **Current and valid government-issued ID card (e.g., State of Florida Identification Card or Driver's License in the name of the client with a Miami-Dade County address)**
- □ **Rental lease agreement (in client's name)**
- □ **Mortgage or rent receipts (in client's name)**
- □ **Utility bills with a Miami-Dade County address (in client's name)**
- □ **Declaration of Domicile letter (Form 578) as issued by the Miami-Dade County Courthouse**
- □ **Department of Corrections Certification**
- □ **"Correction Health Services Referral" form from Jackson Health System's Jail Linkage Program if signed and dated by client and referring party; form is acceptable for the first six months after enrollment in Part A, only once client is released from jail**
- □ **Self-declaration of homelessness**
- □ **A zero income letter from a shelter or residential treatment facility located in Miami-Dade County**
- □ **Head of Household (HOH) letter <u>ONLY</u> if the client physically resides at same address of person completing HOH letter**
- □ **Screen print from a property search of the Miami-Dade County Tax Collector website (https://www.miamidade.county-taxes.com/public) IF the residence is listed in the client's name and it is the client's PRIMARY residence**
- □ **Statement of No Income and Local Residence Form (for clients up to 25 years of age, where applicable)**
- □ **Any government (local, state or federal) issued letter of award that is not older than 12 months from the date of issue and that includes the client's full name and a current address in Miami-Dade County that agrees with the current address in the client file**

<u>4) ADDITIONAL REQUIREMENT FOR OUT OF NETWORK (OON) REFERRALS ONLY –</u>

- □ **<u>For all OON Referrals:</u> Viral Load Lab Results** ***(CURRENT - less than 6 months old).***

(NOTE: Viral load tests should be ordered during the first Test & Treat / Rapid Access medical visit, but a copy of the test result is not required if this referral is for GR Short-term Medication Assistance.)

- □ **<u>For Oral Health Care (dental) referrals only:</u> attach a copy of most recent CD4 count and HIV viral load test results, provide name of HIV antiretroviral medication, and complete the following:**

HIV Specialist/PCP Name: ________________________________
Phone Number: ____________________ **Fax Number:** ____________________

List Any Known Allergies: ________________________________

- -

-- See next page for additional guidance --

****FEDERAL POVERTY LEVEL (FPL) CAPS: The financial requirements (% of FPL) vary depending on the core medical or support service for which a client is referred. For income eligibility related to a particular support service, please see below, call the agency to which the referral will be made, or review the local Ryan White Program Service Delivery Guidelines (SDG). The most current version of the local SDG is available at: http://www.miamidade.gov/grants/ryan-white-program.asp#Delivery.**

CORE MEDICAL SERVICES (400% FPL): AIDS Pharmaceutical Assistance (Local Pharmaceutical Assistance Program), Health Insurance Assistance, Medical Case Management (including Treatment Adherence Services), Mental Health Services, Oral Health Care, Outpatient/Ambulatory Health Services, and Substance Abuse Outpatient Care

SUPPORT SERVICES (maximum % FPL is indicated below):
Food Bank (250%), Medical Transportation (250%), Other Professional Services (Legal Services and Permanency Planning) (200%), Outreach Services (400%), and Substance Abuse Services (Residential) (300%).

This space for use by Ryan White Part A Agency RECEIVING referral only:

CIS#: _____

OUT OF NETWORK (OON) / NON-CERTIFIED REFERRAL DEMOGRAPHICS

for Miami-Dade County Ryan White Part A/MAI Program Services

Please complete the following demographic information for program reporting purposes, and include this page with the referral form and supporting documentation:

CLIENT INFORMATION:

DOB: ___/___/_____ **Zip Code:** _____
mm / dd / yyyy

Birth Gender: _____ *Male* _____ *Female*

Self-Reported Gender: _____ *Male* _____ *Female* ____ *Other* ____ *Not reported/Unknown/Does Not Fit Within Available Options*

Race: *(Choose all that apply)*

___ ***Asian***
- ___ *Asian Indian*
- ___ *Chinese*
- ___ *Filipino*
- ___ *Japanese*
- ___ *Korean*
- ___ *Vietnamese*
- ___ *Other Asian (_____)*

___ ***Black or African American***

___ ***Native American /Alaskan Native***

___ ***Native Hawaiian/Pacific Islander***
- ___ *Native Hawaiian*
- ___ *Guamanian or Chamorro*
- ___ *Samoan*
- ___ *Other Pacific Islander (_____)*

___ ***White***

Ethnicity: *(Choose from the following, as applicable)*

___ ***Haitian***

___ ***Hispanic/Latino/a or Spanish origin***
- ___ *Mexican, Mexican American, Chicano/a*
- ___ *Puerto Rican*
- ___ *Cuban*
- ___ *Another Hispanic, Latino/a, or Spanish origin (_____)*

Birth Country: _____

Native Language: _____ **Preferred Language:** _____

Current HIV Level: ____ ***CDC-Defined AIDS*** ____ ***HIV+ Asymptomatic*** ____ ***HIV+ Symptomatic***

Date of Diagnosis: ___/___/___

State where HIV diagnosis was made: _____ **Within Miami-Dade County: Yes/No** ____

Primary Risk Factor for HIV Infection:
- ___ MSM (male-to-male sexual contact)
- ___ IDU (injection drug use)
- ___ Heterosexual contact
- ___ Hemophilia/Coagulation Disorder
- ___ Receipt of blood transfusion, blood components, or tissue
- ___ Perinatal transmission
- ___ Risk factor not reported or not identified above

Current Housing/Living Arrangement:

___ Stable/Permanent ___ Temporary ___ Unstable