

State of Connecticut Department of Social Services

Connecticut AIDS Drug Assistance Program

C A D A P

WHAT IS CADAP?

The Connecticut AIDS Drug Assistance Program (CADAP) is administered by the Department of Social Services (DSS) under a Memorandum of Agreement (MOA) with the Department of Public Health (DPH). CADAP is a pharmaceutical assistance program that pays for HIV/AIDS medications approved by the U.S. Food and Drug Administration (FDA) and other drugs that may prevent the serious deterioration of health in persons who have Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS).

CADAP COVERAGE

Under the pharmaceutical assistance portion of the program, CADAP pays only for drugs covered under its formulary. If your application is approved, you will receive a program eligibility card. **Take this card to your pharmacist.** Your pharmacist will bill the State directly for drugs covered under CADAP (minus any other insurance coverage you may have). A complete listing of drugs covered under CADAP is sent with the CADAP approval letter and can also be found on the DSS website www.ct.gov/dss under Programs & Services → People with HIV/AIDS → CADAP.

CADAP ELIGIBILITY

In order to be eligible for CADAP, you **must**:

- be a Connecticut resident
- be diagnosed by a licensed physician as having at least one of the following medical conditions:
 - (1) Human Immunodeficiency Virus (HIV) positive, not AIDS
 - (2) Human Immunodeficiency Virus (HIV) positive, AIDS status unknown
 - (3) Acquired Immunodeficiency Syndrome (AIDS) defined by the Center for Disease Control (CDC)
- have a total individual or family net income or Modified Adjusted Gross Income (MAGI) at or below 400% of the current Federal Poverty Level (FPL)
- apply for health coverage, including Medicaid, through the Health Insurance Marketplace, Access Health CT, and submit proof of your approval or denial or provide proof of your current insurance coverage.

There is no asset limit

In order for us to determine your income eligibility, **you must report your net monthly income.** Net monthly income is the sum of your gross earned income received in a calendar month minus any required deductions (such as taxes or deductions for health insurance premiums) and your unearned income, which is the amount you receive from any benefits, such as SSI or SSDI.

You are **not** eligible for CADAP if you are eligible for coverage through:

- Medicaid/Title XIX (Husky A,B,C)
- Medicaid Coverage for the Lowest-Income Populations (Husky D)

****NEW as of January 1, 2014****

Access Health CT is Connecticut's Health Insurance Marketplace. Access Health CT will help you shop for health coverage that meets your needs and fits your budget. It's where individuals, families, and small businesses can go online to search for and enroll in health coverage, including Medicaid and the Children's Health Insurance Program (CHIP), also known as the HUSKY Health program.

The Affordable Care Act (ACA) has allowed Connecticut to expand its income eligibility limits for Medicaid to cover more people. The expansion will cover Adults without dependent children, earning up to 138% of the Federal Poverty Level.

For details and to find out if you qualify visit www.accesshealthct.com or call 1-855-805-health (4325).

TTY users should call 1-855-789-2428.

ELIGIBILITY RENEWAL FOR CADAP

CADAP eligibility must be reviewed and renewed every six months!

Medical Information **must** be completed with Diagnosis, CD4 Count and date of test within last 12 months, Viral Load (VL) and date of test within last 12 months, **and** signed by a Physician, Physician Assistant, or an Advanced Practice Registered Nurse (APRN) **every six months** to continue CADAP eligibility.

Approximately **sixty (60) days** before the expiration of your eligibility, the Department will mail you a renewal application. In order to maintain your CADAP eligibility, you must complete and sign the renewal application and return it to the CADAP mailing address by the due date on the notice.

MEDICAL INSURANCE UNDER CADAP

You may be eligible for CADAP, even if you now have a private medical insurance plan with prescription drug benefits. If you have a private insurance plan with prescription drug coverage, you **must** attach a readable copy of your medical/prescription insurance card (front and back) along with the application. The Department of Social Services may provide premium assistance on medical insurance policies for eligible CADAP clients. If you would like the Department to pay for your private insurance premiums, please see below for more information on the Connecticut Insurance Premium Assistance (CIPA) program. **If your insurance policy is terminated or changes, please notify the CADAP office immediately, and send us a copy of the policy termination letter.**

MEDICARE PRESCRIPTION DRUG COVERAGE (Part D) UNDER CADAP

Eligible CADAP clients who have Medicare Part A and/or B **must** enroll in a Medicare Part D Prescription Drug Plan (PDP). It is important to remember that CADAP will only pay monthly premiums for clients enrolled in a Connecticut-approved benchmark Medicare Part D Plan. The benchmark Part D Plans change every year, so it is important for you to review your plan toward the end of each year to determine if it will remain benchmark. If it will no longer be a benchmark plan in the following calendar year, you may want to switch plans prior to January 1st. **CADAP is always the payer of last resort.** If you are eligible for other insurance, you must apply for and use that insurance first. For general information, or if you need assistance in selecting a PDP, please contact:

- CHOICES at 1-800-994-9422 or www.medicareadvocacy.org
- MEDICARE at 1-800-633-4227 or www.medicare.gov
- Your local pharmacist

Additionally, if you are single and your income is less than \$17,235 **and** the value of your assets is less than \$13,300; **or** if you are married and your combined income is less than \$23,265 **and** the value of your combined assets are less than \$26,580, then you **must** apply for **Social Security Administration's Low Income Subsidy (LIS)**. If you qualify for LIS Extra Help, you will be eligible for significantly reduced prescription co-pays and/or little or no monthly premium. Applications for LIS Extra Help can be obtained from your local Social Security Office or on-line at www.ssa.gov.

Countable assets include:

- Real Estate, such as: rental property, vacant land, and out-of-state property
- Cash Surrender Value of Life Insurance/Death Benefits only if total benefit amount exceeds \$1,500 / person
- Non-Essential Motor Vehicles, Boats, Campers, Recreational Vehicles, Trailers, Motorcycles, etc.
- Bank/Credit Union Savings, Checking, Cash Account(s)
- Christmas club and/or other account
- Annuities, Stocks, Bonds, U.S. Saving Bonds, or Mutual Funds
- Trust Funds, CD's, IRA's, 401K

Countable assets do not include:

- Primary residence
- Burial Plots (up to \$1,500 value)
- Personal Possessions
- One vehicle per person

Please note: If you have private insurance that is considered 'creditable' coverage by Medicare and have been notified of such coverage by your private insurance plan, you do not need to enroll in Medicare Part D.

HOW TO APPLY FOR CADAP?

Please complete Sections I, II, III, and V of the attached CADAP application form. Your medical provider must complete Section IV. Mail the completed application (all sections) to the CADAP mailing address below:

**Department of Social Services
Medical Operations Unit #4
75 Hct o lpi vqp 'Cxgpgw'
Hartford, CT 06107-5952**

SHOULD I NOTIFY THE CADAP OFFICE OF ANY CHANGES?

Yes! Please notify the CADAP office when **any** of the following changes occur:

- Your name or address is changed
- Your private medical insurance policy is changed or terminated
- Your Medicare Part D PDP is changed or terminated
- Your contact person and/or authorized representative have changed.

FOR MORE INFORMATION ON CADAP, CALL THE TOLL-FREE NUMBER: 1-800-233-2503

You may obtain an updated CADAP formulary and application by calling the program's toll-free number or visiting the Department's web-site at: <http://www.ct.gov/dss>

CIPA COVERAGE

The Connecticut Insurance Premium Assistance (CIPA) Program can pay up to \$1,500 per month for health insurance premiums for eligible CADAP clients. CIPA will pay your health insurance premiums directly to the insurance company. If your insurance is sponsored by your employer, CIPA (with your approval) will pay your insurance premiums directly to your employer (upon employer approval of third party payment), or to the COBRA administrator or health insurance administrator. CIPA will pay insurance premiums for your current insurance plan or a plan that you are applying for. CIPA will only pay for insurance plans that: offer drug coverage that is equivalent to the CADAP formulary and comprehensive primary care services.

CIPA will not pay health insurance premiums for policies that have a mandatory mail order pharmacy component if the mail order pharmacy is NOT enrolled as a Connecticut Medicaid Provider; or for policies that have coverage limits on prescription and/or medical benefits. If the insurance premium includes an amount for family coverage, only the portion of the premium that belongs to the individual(s) receiving benefits under CADAP will be covered.

FOR MORE INFORMATION ON CIPA, CALL THE TOLL FREE NUMBER: 1-855-888-CIPA (2472)

Fax: 1-855-888-3300 | Website: www.MyCIPA.com | Email: CustomerService@MyCIPA.com

It is important to know that because continued funding is uncertain, the scope of services and conditions of participation in CADAP or CIPA may change in the future.

All information is kept strictly confidential!

Services are available without regard to race, sexual orientation, color, creed, sex, age, disability, national origin, ancestry, language barriers, or political beliefs.

Deaf and hearing-impaired individuals may use a TDD/TTY by calling 1-800-842-4524.

Questions, concerns, complaints, or requests for information in alternative formats must be directed to the Public and Government Relations Office at 1-800-842-1508.

The Department of Social Services is an equal opportunity, affirmative action employer.

CONNECTICUT AIDS DRUG ASSISTANCE PROGRAM (CADAP) APPLICATION

Section I – Applicant and Household Information

- 1. First Name Middle Initial Last Name
2. Are you currently eligible for any of the following programs administered by the Department of Social Services? Medicaid or MLIA (HUSKY A, B, C, or D) Yes No If yes, your Client ID No.:
3. Residential Address: (Applicants must be a CT resident to be eligible for CADAP)
4. Confidential Mailing Address: (Program notices will be sent to this address)
5. Telephone No.: (home) Area Code
6. Date of Birth: / /
7. Gender: Male Female Transgender If applicable, please provide Transgender Status: Male-to-Female Female-to-Male Unknown
8. Ethnicity: Are you Hispanic or Latino(a)? YES NO
9. Race: Asian (A) American Indian or Alaska Native (N) Black or African American (B) Native Hawaiian / Pacific Islander (P) White / Caucasian (C) Other (O):
10. Primary Language: English Spanish (You will receive all notices from DSS in this language.)
11. Social Security Number: - - (If you have not been assigned a Social Security Number, write in the letters N/A for not applicable.)
12. Pregnancy Status (females only): Are you currently pregnant? YES NO If yes, what is your due date?
13. Contact Person, if you cannot be reached (optional)
14. Authorized Representative, e.g. Conservator, Guardian, Case Manager, Power of Attorney, etc. (This person will receive program notices sent by the Department of Social Services.)

Applicant Name: Applicant DOB:

CONNECTICUT AIDS DRUG ASSISTANCE PROGRAM (CADAP) APPLICATION

Section I – Applicant and Household Information (continued)

LIVING ARRANGEMENT:

My current housing / residential status is Permanent (Stable) Temporary Unstable/Unknown

Check off box that applies and provide information for ALL household members below:

- live alone live with parent/guardian(s) live with non-relatives
- live with spouse/significant other live in a shelter/ homeless live with my children
- live with relatives other than spouse, parents, and child

Financial eligibility is determined by your household size and total monthly net income.

Please list all members of your household and their monthly net income below:

<p>1. Full Name _____</p> <p>Date of Birth _____</p> <p>Relationship: _____</p> <p>Monthly Net Income: \$ _____</p>	<p>2. Full Name _____</p> <p>Date of Birth _____</p> <p>Relationship: _____</p> <p>Monthly Net Income: \$ _____</p>
<p>3. Full Name _____</p> <p>Date of Birth _____</p> <p>Relationship: _____</p> <p>Monthly Net Income: \$ _____</p>	<p>4. Full Name _____</p> <p>Date of Birth _____</p> <p>Relationship: _____</p> <p>Monthly Net Income: \$ _____</p>

Section II – Financial Information

FOR CADAP:

Your **monthly net income** is needed to determine eligibility for CADAP. Net monthly income is your monthly gross earned income minus any deductions (such as taxes or deductions for health insurance premiums) plus your unearned income, which is the amount you receive from any benefits such as SSI or Social Security.

What is the total monthly net income received by all members of your family? \$ _____

FOR MEDICAID ELIGIBILITY DETERMINATION:

A preliminary determination of your Medicaid eligibility will be made on the basis of the following information. This information is used solely by the CADAP program and does not mean you have started the application process for Medicaid/Title XIX.

A separate application must be submitted to your local DSS office, or via the Health Insurance Marketplace, Access Health CT, if you want to be screened for Medicaid eligibility.

To request that a Medicaid application be sent to you, please call 1-800-842-1508 or visit www.accesshealthct.com to see if you qualify online.

Do you receive Social Security or SSI benefits based on disability? Yes No

Please indicate the total monthly income for all members of your household below:

Gross Monthly Earned Income: \$ _____

Gross Monthly Unearned Income: \$ _____

Cash, Saving/Checking Accounts, Liquid Assets: \$ _____

Stocks / Bonds: \$ _____

Applicant Name: _____ Applicant DOB: _____

CONNECTICUT AIDS DRUG ASSISTANCE PROGRAM (CADAP) APPLICATION

Section III – Insurance Coverage Information

If you or anyone in your family currently have health insurance (medical and/or prescription coverage), please fill out the following section.

1. Health Insurance Information

Please check off the box that best describes your health insurance policy:

- Health insurance through an employer (individual or group) Self-purchased (individual or group)
 COBRA or similar continuation coverage Other: _____

Insurance Company Information:

Insurance Company Name:	Effective Date on Policy: / /
Address:	Policy Number:
	Group Number:
Member Services Contact (if known):	Member Services Phone #: () -

Please include a copy of your insurance card (front and back) with this application. If your insurance policy is terminated, please notify the CADAP office immediately and submit the policy termination letter to the CADAP office as soon as possible!

Have you applied for the Connecticut Insurance Premium Assistance Program (CIPA)? YES NO

If yes, what is your application status at this time? Approved Pending Denied

2. Medicare Benefits

Do you receive Medicare Part A and/ or Part B Benefits? YES NO

If yes, what is your Medicare Claim #? _____

Are you enrolled in a Medicare Part D Prescription Drug Plan (PDP)? YES NO

PDP Company / Name: _____

PDP Policy Number: _____

Policy Effective Date: Start _____ Stop _____

Please attach a copy of your Medicare Card and /or Medicare Part D PDP Card (front and back) with this application.

3. Health Care Benefits from the Department of Veteran Affairs (VA)

Are you a veteran? YES NO

If yes, are you currently receiving VA medical benefits? YES NO

Please Note: Individuals eligible for VA medical benefits are encouraged to apply for those services and use them first but can also apply for and receive CADAP services in addition to or in lieu of their VA healthcare benefits.

4. Have you applied for benefits through Access Health CT? YES NO

If yes, what is your application status at this time? Approved Pending Denied

(Please attached proof of your Access Health CT application)

Applicant Name: _____ Applicant DOB: _____

CONNECTICUT AIDS DRUG ASSISTANCE PROGRAM (CADAP) APPLICATION

Section IV – Medical Information

This 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 drug(s) to treat HIV disease or to prevent serious deterioration of health arising from HIV disease, including measures for the prevention and treatment of opportunistic infections for the below patient:

APPLICANT/PATIENT NAME: _____ **DOB:** _____

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

- (1) HIV+, not AIDS
- (2) HIV+, AIDS status unknown
- (3) CDC-Defined AIDS

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

CD4 Count (CD4): _____ Test Date: _____

HIV Viral Load (VL): _____ Test Date: _____

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

Physician/Physician Assistant/APRN Signature Date

Office Address and Telephone Number

PLEASE NOTE: Section IV – Medical Information must be completed and signed by a Physician, Physician Assistant, or an Advanced Practice Registered Nurse every six months to remain eligible for CADAP and must accompany your completed initial application and/or redetermination application to continue CADAP eligibility.

CONNECTICUT AIDS DRUG ASSISTANCE PROGRAM (CADAP) APPLICATION

Section V – Release

I hereby authorize and permit the Department of Social Services (Department) and/or its agents to use and disclose records in its possession including those **that contain confidential HIV-related information, as defined in Section 19a-580 of the Connecticut General Statutes**, indicating that _____ (*patient's name*), a Connecticut AIDS Drug Assistance Program (CADAP) applicant or client, has Human Immunodeficiency Virus (HIV) infection, HIV-related illness, or Acquired Immune Deficiency Syndrome (AIDS) to Department employees and agents, CADAP/Medicaid pharmacies, health insurers, medical or social services providers and auditors, for purposes associated with the administration of CADAP and the other programs administered by the Department.

I also authorize and permit the Department and its agents to contact my employer(s), billing company, COBRA Administrator, or health insurers, for purposes associated with the establishment of premium payments on my behalf through the Connecticut Insurance Assistance (CIPA) Program and administration of CADAP and all other programs administered by the Department.

This authorization is valid for the duration of any functions related to the operation of CADAP and all other Department programs for six months from the date of the signature below.

Date Signed

Signature of CADAP applicant or client

Date Signed

Signature of Legal Guardian of the CADAP applicant or client

Date Signed

Signature of person authorized to consent to health care for the CADAP applicant or client

Section VI – Signature

- 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 Sections 53a-157b and 17b-97 of the Connecticut General Statutes 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 agree to notify the Department of Social Services 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 medical bills, 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 Social Services concerning my eligibility of CADAP, I have the right to request a hearing within **60 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 Social Services – "77 Hcto kpi vqp Cxg" – Hartford, Connecticut 06107-5952. I may also call (860) 424-5760 or toll-free 1-800-462-0134 for more information regarding a hearing.

Signature of Applicant or Client

Date

Signature of Authorized Representative

Date

Please mail the original completed and signed application to:

Department of Social Services
Medical Operations, Unit # 4
77 Hcto kpi vqp Cxg"
J ct hqtf ".EV"28327/5952"

Applicant Name: _____ Applicant DOB: _____