

**ADAP Wrap-Around Pilot Project (AWAPP)
DOCUMENT CHECK LIST**

- Notice of Eligibility for HIV/AIDS Patient Care Programs
- SSA Medicare Prescription Drug Assistance Award Letter
(Specifying Low Income Subsidy Status)
- Copies of Medicare and Medicare Part “D” cards (front & back)
- Description of Prescription Drug Member Benefit from Part D provider
(Specifying applicant pays 15% of drug co-pays)
- Printout from pharmacy of prescription costs and co-payment amounts

**Please submit ALL documents with complete AWAPP application packet.
Applications sent without full documentation cannot be processed.**

**Return complete application packet to Francia Alcala at the secure fax number
305-592-0981. If you have any questions, please call 305-592-1452 ext. 121.**



FOR AWAPP OFFICE USE ONLY:

AWAPP #: _____

DATE APPROVED: _____

ADAP Wrap-Around Pilot Project (AWAPP) APPLICATION FORM

ALL APPLICATION INFORMATION MUST BE PROVIDED. IF A QUESTION DOES NOT APPLY, PLEASE WRITE "NA" IN THE SPACE PROVIDED. INCOMPLETE APPLICATIONS CANNOT BE PROCESSED.

ASSURANCE OF CONFIDENTIALITY:

All information that you have provided on this application will be kept strictly confidential to the fullest extent as defined by state and federal law. The Client Consent to Fax Confidential Information, Authorization for Release of HIV/AIDS Information, Memorandum of Understanding and Confidentiality of Client Information should be completed prior to submission and are all applicable to this AWAPP Application Form.

IDENTIFICATION INFORMATION:

First Name: _____ Last Name: _____

Social Security Number: _____ Gender: Male Female

Date of Birth: _____ Age: _____

Race: White Black Asian Native American/Alaskan Native
 Pacific Islander Multiple Races Other

Ethnicity: Hispanic Non-Hispanic

CONTACT INFORMATION:

Secure Mail Address: _____ Apt. #: _____
Number and Street

_____ Zip: _____
City and County

Secure Phone Number: _____

PROGRAMMATIC REQUIREMENTS:

YES NO

Applicant meets HIV/AIDS patient care program eligibility criteria?
(Attach Notice of Eligibility)

Applicant income is between 135% - 150% of FPL?

Applicant has Medicare Part "A", "B, and "D" coverage?

Applicant qualifies for LIS (Low Income Subsidy)?
(Attach SSA Medicare Prescription Drug Assistance Award Letter)

Does the Applicant have a secondary private health policy?

Does the Applicant have Medicaid?

HEALTH INSURANCE INFORMATION: A current photocopy of both sides of your standard Medicare card and your Medicare Part D card MUST be attached to this submitted application.

Insurance Documentation-Provided Medication Co-Payment Amount: \$ _____

Insurance Documentation-Provided Annual Policy Deductible Amount: \$ _____

I declare that all statements made on this data collection form are true and complete to the best of my knowledge and I REALIZE THAT WILLFUL FALSIFICATION OF THIS INFORMATION BY ME MAY SUBJECT ME TO IMMEDIATE DISQUALIFICATION FOR PARTICIPATION IN THE AWAPP. I ALSO UNDERSTAND THAT IF I QUALIFY FOR PARTICIPATION, THE AWAPP MAY STOP PAYING MY ANNUAL DEDUCTIBLE, CO-INSURANCE & CO-PAYMENTS IF FUNDING FOR THIS PROJECT RUNS OUT. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO SUPPLY THE HEALTH COUNCIL OF SOUTH FLORIDA, INC. WITH THE RECEIPTS AND PAYMENT VOUCHERS FOR ANNUAL DEDUCTIBLE, CO-INSURANCE & CO-PAYMENTS SO THAT PAYMENTS TO THE PROVIDER(S) IS PAID IN A TIMELY MANNER. I also understand that I must be redetermined eligible for AWAPP services every 6 (six) months. I release this complete applicant data form to the Health Council of South Florida, Inc. for eligibility determination and data collection.

Applicant's Signature

Date

As Witnessed and submitted by:

Printed name of Case Manager/ADAP Contact

Signature of Case Manager/ADAP Contact

Date

Case Management Agency/County Health Department

Phone

Case Management/County Health Department Address

City, and Zip



AWAPP #: _____
(AWAPP OFFICE USE ONLY)

RELEASE OF INFORMATION

I hereby authorize any physician, hospital, pharmacy, insurance company, employer or other person or organization processing medical information, claims information, or information concerning employment, of me or any dependent including my spouse (if applicable) to permit **HEALTH COUNCIL OF SOUTH FLORIDA, INC.** to be furnished with copies and be given details of all such medical information concerning care, treatment, services and charges regarding & HIV/AIDS status and treatments). **I ACKNOWLEDGE THAT THIS AUTHORIZATION IS EFFECTIVE INDEFINITELY AND THAT A FACSIMILE OR COPY OF IT IS AS EFFECTIVE AS THE ORIGINAL.**

HEALTH COUNCIL OF SOUTH FLORIDA, INC. is requesting information regarding:

Insured's Name (printed): _____

Social Security #: _____

Insured's Signature

Date

Witness' Signature

Date

Please mail requested information to: **Health Council of South Florida, Inc.**
AWAPP
8095 NW 12 Street, Suite 300
Miami, Florida 33126

EFFECTIVE JULY 2006

RELEASE OF MEDICAL INFORMATION

In addition to the state and federal statutes that require informed consent prior to release of medical information, Department of Health Security Protocols 7.1,V., D. and 16.V. F. require a specific written consent to be signed by the client prior to faxing any of that client's confidential HIV/AIDS, STD or TB information. This form is to be used when a client is requesting that you fax his/her information to a provider or receive his/her information from a provider by fax. This form does not replace the client's consent to release confidential information form (DH 3111), but should be utilized in conjunction with the DH 3111 for medical records information, or without the DH 3111 when faxing confidential information that is not part of the medical record (i.e., initial test results). Anonymous HIV test results can be received by fax from the laboratory **only if** the client presents the blue copy of the Test Request Form (DH 1628) at the time of request.

Instructions for Completion of Consent to Fax

1. Every client requesting that confidential information, as described be sent or received by fax must complete and sign this form.
2. Complete the identification information in the bottom right hand corner of the form, using the patient's name, ID # and date of birth (DOB).
3. Enter the client or legal representative's name after the first I.
4. Enter the name and address of the unit of the department authorized to send or receive the faxed confidential information.
5. Check all boxes that apply to the information that will be sent or received by fax.
6. Complete the provider name, contact person, phone number, and fax number for the recipient of the faxed information. This could be a health department or non-health department provider.
7. The client or legal representative must sign and date the form. If the form is signed by the legal representative, the relationship to the client must be noted.
8. Department staff must sign as the witness to the client or legal representative signature.
9. If the client or legal representative chooses to withdraw the consent to fax, it must be done on the completed release form in the box provided at the bottom of the page. The client or legal representative must sign and date the form. If the form is signed by the legal representative, the relationship to the client must be noted. Department staff must sign as the witness to the client or legal representative signature. The withdrawal of consent is effective upon signature.

Memorandum of Understanding

Confidentiality of Client Information

The purpose of this memorandum of Understanding is to emphasize that all information held in health records is confidential, with access governed by the state and federal laws. Information that is confidential includes a client's name; address; medical; social; and financial data; and services received. In addition, the fact that someone has had an HIV test is confidential, whether the result of that test is negative or positive. Data collection by interview, observation or review of documents should be conducted in a setting that protects the client's identity from unauthorized individuals. Client information should not be discussed outside the agency, except in the performance of referrals to other agencies for client care.

Section 384.29, Florida Statutes, addresses the need for special discretion in the handling of sexually transmissible disease information. Sexually transmissible diseases, by their nature, involve sensitive issues of Privacy and all programs designed to deal with these diseases should afford privacy and confidentiality to the client.

Section 381.004, Florida Statutes, deals with confidentiality of HIV test results. There are penalties for violating this statute. These penalties range from disciplinary action by the agency to a criminal misdemeanor.

I understand and agree to abide by these confidentiality provisions.

Employee Signature

Date