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 with the Department of Public Health. 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 Immune-deficiency Virus (HIV) or Acquired Immune Deficiency 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.

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:
  - Human Immunodeficiency Virus (HIV) positive, not AIDS (1)
  - Human Immunodeficiency Virus (HIV) positive, AIDS status unknown (2)
  - Acquired Immunodeficiency Syndrome (AIDS) defined by the Center for Disease Control (CDC) (3)
- have a total individual or family net income at or below 400% of the current Federal Poverty Level.

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.

If you are determined eligible for CADAP, you **must** apply for Medicaid (Title XIX) as a condition of eligibility.

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

- Medicaid (**Title XIX**)
- Medicaid for Low Income Adults (**MLIA**)

ELIGIBILITY RENEWAL FOR CADAP

CADAP eligibility must be reviewed and renewed every six months!

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

Approximately sixty 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 **<u>must</u>** 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 **<u>must</u>** 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. **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 $16,335 **and** the value of your assets is less than $13,070; **or** if you are married and your combined income is less than $22,065 **and** the value of your combined assets are less than $26,120, then you **<u>must</u>** 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 <u>only</u> 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)
- Annuities, Stocks, Bonds, U.S. Saving Bonds, or Mutual Funds
- Christmas club and/or other account
- Trust Funds, CD's, IRA's, 401K

Countable assets do not include:

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

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 physician must complete Section IV. Mail the completed application (all sections) to the CADAP mailing address below:

Department of Social Services
Medical Operations Unit #4
25 Sigourney Street
Hartford, CT 06106-5033

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. 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 equal to or better than the current 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) or Charter Oak ❑ Yes ❑ No If yes, your Client ID No.:______________

If you are eligible for any of the above programs, you are not eligible for CADAP unless you are currently on a spenddown.

3. **Residential Address:**

Street Address Box or Apt. #

City State Zip Code

4. **Confidential Mailing Address:**
(Program notices will be sent to this address)

Street Address Box or Apt. #

City State Zip Code

5. **Telephone No.: (________)** ____________________
(home) *Area Code*

Telephone No.: (________) ____________________
(cell) *Area Code*

6. **Date of Birth:** _______/_______/________
Month Day Year

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)***

Name: First M.I. Last

Street Address Box or Apt. #

City State Zip Code

Telephone No.: (__________) ____________________
Area Code

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.)*

Name: First M.I. Last

Street Address Box or Apt. #

City State Zip Code

Telephone No.: (__________) ____________________
Area Code

Applicant Name: ______________________________ Applicant DOB: _______________________

LIVING ARRANGEMENT:

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

Members of Household:

I currently… (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 family size and your family's net monthly income. Your family includes the following relatives who live with you: your spouse, your children under 18, and your parents if you are under age 18.

1. Full Name________________________________

Date of Birth______________________

Sex ☐ M ☐ F

Relationship:______________________________

Monthly Net Income: $______________________

2. Full Name________________________________

Date of Birth______________________

Sex ☐ M ☐ F

Relationship:______________________________

Monthly Net Income: $______________________

3. Full Name________________________________

Date of Birth______________________

Sex ☐ M ☐ F

Relationship:______________________________

Monthly Net Income: $______________________

4. Full Name________________________________

Date of Birth______________________

Sex ☐ M ☐ F

Relationship:______________________________

Monthly Net Income: $______________________

Section II – Financial Information

FOR CADAP:

Your **monthly net income** is needed to determine eligibility. Net monthly income is your monthly gross earned income minus any required deductions (such as taxes, deduction for health insurance premiums, and unpaid medical expenses incurred) plus your unearned income, which is the amount from any benefit(s) received, such as SSI or Social Security.

The total monthly net income received by all members of your family is: $__________________

FOR MEDICAID ELIGIBILITY DETERMINATION:

A preliminary determination of your Medicaid eligibility will be made on the basis of the following information. Verification of your income will be required as part of your Medicaid application.

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

Indicate your family's / household members' income:

Gross Monthly Earned Income: $_________________

Gross Monthly Unearned Income: $_________________

Cash, Saving/Checking Accounts, Liquid Assets: $_________________

Stocks / Bonds: $_________________

What other help do you need?

☐ Money Assistance ☐ Help with Child Care ☐ Food Stamp Assistance (SNAP)
☐ Other *(Specify)*:____

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)

☐ COBRA or similar continuation coverage

☐ Self purchased (individual or group)

☐ 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!

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.

Applicant Name: ______________________ Applicant DOB: ____________________

CONNECTICUT AIDS DRUG ASSISTANCE PROGRAM (CADAP) APPLICATION
Section IV – Medical Information

This section must be fully 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 for the above applicant/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.

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 one year 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 – 25 Sigourney Street – Hartford, Connecticut 06106-5033. 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
25 Sigourney Street
Hartford, CT 06106-5033

Applicant Name: ______________________ Applicant DOB: ____________________

CADAP STAFF

Initial Application_______________ Reapplication_______________

Client ID No._______________ Region_______________

Medicaid/MLIA (Husky A,B,C,D)	**AU NO.**	**DATE**
Name Not Found on Elig. File	________	________
Granted Medicaid	________	________
Spenddown ❑ Active Med.	________	________
❑ Not Active Med.	________	________
Pending	________	________
Denied	________	________
Closed	________	________

CADAP Eligibility Determination

❑ Eligible - CADAP Effective Date:_______________

❑ Not Eligible for CADAP (please provide explanation for denial below)

Worker Name: _______________ Worker ID: _______________

Date Application Received: _______________ Date Application Processed:_______________

Explanation: _______________

REGIONAL OFFICE STAFF

Date Received:_______________ Region: _______________

Worker Name:_______________ Worker ID: _______________

Medicaid Eligibility

When a determination is made, please notify the Central Office CADAP Unit by completing the section below and returning a copy of this application form to the C.O. CADAP Unit. Please fax to (860) 424-4822 or mail to the Department of Social Services, Medical Operations Unit #4, Hartford, CT 06106-5033.

If you have any questions, please contact the DSS C.O. CADAP Unit at 1-800-233-2503

	Medicaid/ MLIA	
Granted	❑	Effective Date:_______________
Denied	❑	Date:__________ Reason: _____
Spenddown Not Active Medicaid	❑	Effective Date:_______________

Publication Number 13, Revised July 2012

Applicant Name: _______________ Applicant DOB: _______________