

# ACKNOWLEDGEMENTS

## ELIGIBILITY WORKGROUP MEMBERS

Martha Buffington	Area 3/13
Jimmy Llaque	Area 10
Patrick Mercier	Area 5/6/14
Javier Romero	Area 11A
Cindy Richardson	Area 2B
Debbie Tucci	Area 7

## ADDITIONAL THANKS TO

Bureau of HIV/AIDS, Community Program Staff  
Bureau of HIV/AIDS, ADAP Staff  
Statewide Patient Care Planning Group  
Consumer Advisory Group

## SPECIAL THANKS TO

Eligibility staff across Florida who work hard every day to ensure access to those most in need of HIV/AIDS services.



## TABLE OF CONTENTS

### **INTRODUCTION**

PURPOSE  
GOAL  
STAFF PROCEDURES MANUAL

### **SECTION 1**

### **GENERAL INFORMATION**

STATUTORY AND PROGRAMMATIC AUTHORITY	1
FLORIDA STATUTES	1
HIV/AIDS STATUTES	1
FLORIDA ADMINISTRATIVE CODE (F.A.C.)	2
STATE/FEDERAL LAWS AND REGULATIONS	2
ALLOWABLE SERVICES	2

### **SECTION 2**

### **CONFIDENTIALITY**

POLICY AND PROCEDURE	1
FORMS	1
<b>DH 1120</b>	1
<b>DH 3204</b>	2
<b>DH 3203</b>	3
<b>DH 2116</b>	3
PHONE CALLS	3
MAILING	3
FAXES	3
EMAIL	4
FIELD SECURITY	4
WORK SPACE	4
STORAGE	4
CLIENT FILE RETENTION	4
ELECTRONIC FILES AND COMPUTERS	5
ADDITIONAL INFORMATION	5

### **SECTION 3**

### **PERSONNEL**

ELIGIBILITY STAFF	1
SUPERVISORY OVERSIGHT	1
SUPERVISOR RESPONSIBILITES	1
STAFF RESPONSIBILITES	1
TRAINING REQUIREMENTS	

**SECTION 4****ELIGIBILITY REQUIREMENTS**

WHO MAY APPLY FOR SERVICES?	1
MINORS SEEKING SERVICES	1
ELIGIBILITY TRQUIRMENTS	1
APPLICANTS RIGHTS	1

**SECTION 5****NEW AND RE-DETERMINATION**

INITIAL CONTACT	1
DETERMINATION OF ELIGIBILITY	1
APPLICATION REQUIREMENT	2
TIME LIMITS	2
ELIGIBILITY REQUIREMENT STAFF ASSESSMENT WORKSHEET	2
REQUIRED DOCUMENTATION IN ELIGIBILITY CHART	2
RE-DETERMINATION	2
APPOINTMENT REMINDERS	3
RE-DETERMINATION DOCUMENTATION PROCEDURES	3
LOCATION OF ELIGIBILITY FILE	3

**SECTION 6****BROCHURE/APPLICATION**

BROCHURE	1
APPLICATION	1
RIGHTS AND RESPONSIBILITES	1
COMPLETING THE APPLICATION	2
FREQUENCY	2
PREGNANCY	2
HOUSING	2
PRESCRIPTIONS	2
INTERPRETERS/ILLITERACY/ILLNESS	2

**SECTION 7****PROOF OF HIV**

ACCEPTABLE PROOF	1
INFORMATION	1
TYPES OF LAB ACCEPTED	1
EXPOSED INFANTS	1
NOT ACCEPTABLE PROOF	1

**SECTION 8****LIVING IN FLORIDA**

LIVING IN FLORIDA DEFINITION	1
DOCUMENTATION	1
HOMELESS	2
WINTER RESIDENCE ONLY	2
IMMIGRATION STATUS	2

USE OF SOCIAL SECURITY NUMBER	2
CREATING ALTERNATE IDENTIFICATION NUMBERS	2

**SECTION 9** **SCREENING FOR OTHER PROGRAMS**

---

PAYOR OF LAST RESORT	1
OTHER FEDERAL STATE AND PROGRAMS	1
MEDICAID	1
MEDICAID SCREENING	2
MEDICARE	2
MEDICARE PART D	2
LOW INCOME SUBSIDY (EXTRA HELP)	2
PATIENCE ASSISTANCE PROGRAM (PAP'S)	3
EXPANDED ACCESS PROGRAMS (EAP'S)	3
MEDICAID PROJECT AIDS CARE (PAC) WAIVER PROGRAM	3
PRESCRIPTION DISCOUNT DRUG PROGRAM	3
TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF)	4
FOOD STAMPS	4
VETERAN ADMINISTRATION (VA)	5
CHILDREN'S MEDICAL SERVICES	5
KIDCARE	5
LOCALS ASSISTANCE PROGRAMS	5

**SECTION 10** **HEALTH INSURANCE**

---

ADEQUATE HEALTH INSURANCE	1
CO-PAYS AND PREMIUMS	1
ELECTING NOT TO USE	1
AIDS INSURANCE CONTINUATION PROGRAM (AICP)	2
SCREENING FOR HEALTH INSURANCE	2

**SECTION 11** **INCOME**

---

FEDERAL POVERTY GUIDELINES	1
DETERMINE INCOME WAIVER	1
GROSS INCOME VERSUS NET INCOME	2
EARNED INCOME, UNEARNED INCOME AND DEEMED INCOME	2
DETERMINING HOUSEHOLD SIZE	3
<b>COUNTED</b>	3
<b>NOT COUNTED</b>	3
<b>COMMINGLED FUNDS</b>	3
DETERMINING HOUSEHOLD INCOME (INCLUDING DOCUMENTATION)	4
<b>INCOME COUNTED</b>	4
<b>SELF EMPLOYED</b>	5
<b>NO INCOME</b>	6
<b>INCOME NOT COUNTED</b>	7
STATE HOPWA EXCEPTION	7
REFUSAL TO DIVULGE	7

HOW TO CALCULATE INCOME	7
FINAL INCOME DETERMINATION	8
CALCULATING THE FEDERAL POVERTY LEVEL	8

**SECTION 12** **REQUESTS FOR EXCEPTION**

---

EXCEPTION CRITERIA	1
WHO SHOULD REQUEST AND EXCEPTION?	1
PROCEDURES FOR REQUESTING AN EXCEPTION	1
TRACKING	2

**SECTION 13** **ELIGIBILITY DETERMINATION**

---

ELIGIBILITY	1
NOTICE OF ELIGIBILITY	1
REFERRALS	1
INELIGIBLE	2
NOTICE OF INELIGIBILITY	2
EXCEPTION VS. APPEAL	3
HEARING PROCEDURES	3
CLOSING THE FILE	3

**ATTACHMENTS**

---

ATTACHMENT A ELIGIBILITY RULE TEXT	A1
ATTACHMENT B GLOSSARY OF SERVICES	A2
ATTACHMENT C COMPUTER USE AND CONFIDENTIALITY AGREEMENT DH 1120	A3
ATTACHMENT D INITIATION OF SERVICES DH 3204	A4
ATTACHMENT E NOTICE OF PRIVACY PRACTICE	A5
ATTACHMENT F AUTHORIZATION TO DISCLOSE DH 3203	A6
ATTACHMENT G CONSENT TO FAX DH 2116	A7
ATTACHMENT H BROCHURE AND APPLICATION	A8
ATTACHMENT I APPLICANTS FINANCIAL SURVEY	A9
ATTACHMENT J ELIGIBILITY STAFF ASSESSMENT WORKSHEET	A10
ATTACHMENT K SIX MONTH RECERTIFICATION REVIEW FORM	A11
ATTACHMENT L NOTICE OF ELIGIBILITY	A12
ATTACHMENT M NOTICE OF INELIGIBILITY	A13
ATTACHMENT N NOTICE OF RIGHTS	A14
ATTACHMENT O INSURANCE WAIVER FORM	A15
ATTACHMENT P MONTHLY FEDERAL POVERTY GUIDELINES	A16
ATTACHMENT Q ANNUAL FEDERAL POVERTY GUIDELINES	A17
ATTACHMENT R SELF EMPLOYMENT TRACKING SHEET	A18
ATTACHMENT S REQUEST FOR EXCEPTION	A19
ATTACHMENT T EXCEPTION REQUEST LOG	A20

## INTRODUCTION

Prior to the promulgation of Chapter 64D-4, Eligibility Requirements for HIV/AIDS Patient Care Programs, Florida Administrative Code F.A.C., the eligibility requirements and procedures varied slightly from one another. The development and implementation of this eligibility manual establish the standardization of the eligibility requirements for all these programs. The procedures can be used within the current eligibility staff and location infrastructure or in a more centralized infrastructure with specific staff and locations identified.

**Purpose** The purpose of the Bureau of HIV/AIDS, Patient Care Program is to provide primary health care and support services to low-income persons living with HIV disease, based on availability, accessibility and funding. The Patient Care Programs are responsible for ensuring services are provided to those intended by establishing eligibility requirements and procedures which will be fairly applied to all who request eligibility for services.

---

**Goal**

- To provide a standardized system of core eligibility across HIV/AIDS Patient Care Programs.
- To prevent duplication of effort.

---

**Staff Procedures Manual** When determining eligibility, the staff procedure's manual:

- Ensures persons requesting services from the Patient Care Programs have been determined eligible or ineligible appropriately.
- Provides eligibility staff with procedures and forms to follow.
- Applies only to the Department of Health, Bureau of HIV/AIDS Patient Care Programs in conjunction with Chapter 64D-4 F.A.C.
- Does not preclude local, state and federal programs from adopting the requirements and procedures referenced in this document.

The information in this manual replaces the eligibility requirement determination procedures established for the AIDS Drug Assistance Program (ADAP), AIDS Insurance Continuation Program (AICP), State Housing Opportunities for Persons With AIDS (HOPWA) and the 2001 Case Management Standards and Guidelines. The programmatic qualifications and requirements can be found in each program's respective manual or guidelines.

---



## SECTION 1: General Information

### Statutory and Programmatic Authority

The statutory authority for the Bureau of HIV/AIDS patient care programs eligibility requirements, process and procedures is stated in Chapter 381, Florida Statutes and Chapter 64D-4, Florida Administrative Code (F.A.C.), hereinafter referred to as the “eligibility rule.” This procedures manual is developed in conjunction with the statute and the eligibility rule requirements.

The “HIV/AIDS Patient Care Programs” include the following:

Ryan White Part B Consortia Program.  
Ryan White Part B AIDS Drug Assistance Program (ADAP).  
Ryan White Part B AIDS Insurance Continuation Program (AICP).  
State Housing Opportunities for Persons with AIDS Program (HOPWA).  
Patient Care Networks (PCN) and County Health Departments (CHD).

Not included under the eligibility rule authority are the HIV/AIDS services provided by other local, state or federal HIV/AIDS patient care programs such as:

Ryan White Part A (Eligible Metropolitan Areas)  
Ryan White Part C  
Ryan White Part D  
Medicaid, PAC Waiver and Medicare  
City HOPWA  
Local indigent programs

---

### Florida Statutes

Chapter 381, Florida Statutes, Public Health. This statute requires the Department of Health to be responsible for the state's public health system which shall be designed to promote, protect, and improve the health of all people in the state. Chapter 381, Florida Statutes is often referred to as Florida's Public Health law, which provides the statutory authority for the Department of Health, Bureau of HIV/AIDS to establish the eligibility requirements and procedures developed through the administrative rulemaking process for the HIV/AIDS Patient Care Programs.

---

### HIV/AIDS

- Section 381.0042, Florida Statutes - Patient Care for Persons with Human Immunodeficiency Virus Infection. This section provides the authority for the Department of Health to establish HIV patient care networks to plan for the care and treatment of persons with HIV/AIDS.

- Section 381.0037, Florida Statutes - This section is specific to HIV/AIDS and addresses the unique nature of the disease by establishing programs and requirements related to HIV/AIDS. Care and treatment programs must balance medical necessity, the right to privacy and protection of the public from harm.
- 

**Florida  
Administrative  
Code (F.A.C.)**

Chapter 64D-4, Eligibility Requirements for HIV/AIDS Patient Care Programs, Florida Administrative Code (Attachment A) is the “eligibility rule” for the Patient Care Programs and was developed through a lengthy process which included statewide input, workshops, public hearings and notification to the affected parties. An administrative rule or code is a legal binding document based on statutory authority.

The eligibility rule states the following:

- Purpose.
- Eligibility definitions.
- Documentation requirements.
- Provisions for determining and re-determining eligibility or ineligibility, and
- Applicant and eligibility staff’s rights and responsibilities.

**It is important that all staff read this rule in its entirety.**

---

**State/Federal  
Laws/Regulations**

Other laws and regulations affecting the Department of Health, Bureau of HIV/AIDS, Patient Care Programs include the Ryan White Treatment Modernization Act of 2006 and the AIDS Housing Opportunity Act (AHOA).

---

**Allowable  
Services**

- The HIV/AIDS Patient Care Programs are eligibility programs and not entitlement programs such as Medicaid and Medicare; therefore, the services provided by these programs are subject to accessibility, availability and funding statewide. This means there may be some services which are not provided in the local service area, but are available elsewhere in the state.
- The services provided are listed in the current federal Glossary of Services as referenced by the Health Resources and Services Administration, (HRSA), and the Department of Health, Bureau of HIV/AIDS. (Refer to Attachment B)

**Please Note:** Eligibility is a prerequisite for enrollment in the specialty programs ADAP, AICP or State HOPWA; however, there are program specific qualifications and requirements.

---

## SECTION 2: Confidentiality

Staff must take prudent and reasonable steps to protect applicant/client confidential information. This section provides minimum criteria regarding security records and the management of confidential information.

The U.S. Department of Health and Human Services (HHS) issued the Privacy Rule to implement the requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Privacy Rule addresses the use and disclosure of individuals' health information - called "protected health information" by organizations subject to the Privacy Rule – called "covered entities." The rule also ensures that individuals' understand and control how their health information is used.

---

### Policy and Procedure

All written and verbal communications with applicants during and after eligibility must be maintained in strict confidence as required by law. These procedures are the same for eligibility and case management agencies.

The Florida Department of Health (DOH) has written security policies, protocols, and procedures to ensure the security of information and protect confidentiality, data integrity, and access to information in accordance with Florida Statute.

- These policies are entitled, Information Security Policy DOHP 50-10-07.
- Contracted and subcontracted providers for DOH HIV/AIDS programs may create their own security policies, protocols and procedures but must be consistent with the DOHP 50-10-07.
- All employees and volunteers with access to client information must receive routine (at least annual) training on confidentiality, the proper exchange of information and required consent. Documentation of training must be maintained in personnel records.

---

### Forms

The following forms have been developed by DOH for the purpose of securing confidential information. Providers are encouraged but not required to use the following DOH forms or must develop similar forms consistent with HIPAA and HIV laws. Staff should check with their agency to determine which forms are utilized.

#### **DH 1120 Computer Use and Confidentiality Agreement**

- Must be completed by the employee and their supervisor after review of each section and must be included in the employee's personnel record.
- Should be completed within the first 30 days of employment.
- Should be modified to meet the needs of the agency. (Attachment C)

If modifying this form, an agency should address, at a minimum, the following subjects:

- An internal and external response to a breach of confidentiality including the understanding by the employee that they can be prosecuted.
- Review of use of DOH software and hardware (Section B of form DH 1120 covers this), if applicable.
- Review and access to the agency policies and procedures.
- Review and access to the agency personnel hand book.
- Review and access to the Florida Statutes and Administrative Rules pertaining to HIV/AIDS services and confidentiality. These can be accessed on the Internet by going to [www.MyFlorida.com](http://www.MyFlorida.com).
- Procedures to ensure the protection and confidentiality of all confidential matters shall be consistent with the DOHP 50-10-07.

**DH 3204 Initiation of Services**

- Completed by the applicant/client.
- Allows the agency to obtain or provide necessary information on the applicant/client related to treatment, payment and health care operations.
- Allows for alternative methods of communication which applicant/client must initial next to all applicable.
- Is in effect indefinitely unless the applicant revokes the form. (Attachment D)

**Notice of Privacy Practices**

- Given to the client when they sign DH 3204 upon initial enrollment and as necessary or requested by the applicant/client.
- Describes how medical information about the applicant may be used and/or disclosed, and how the applicant/client can get access to this information. (Attachment E)

**DH 3203 Authorization to Disclose Confidential Information**

- Establishes written documentation that the applicant/client has given permission to disclose protected health information for purposes other than treatment, payment or health care operations.
  - Examples include attorneys, caregivers, spouses and partners. Information provided to the person on the release should be on a “need to know” basis and be pertinent to the applicants/clients care. (**Need to know** is defined as **1.** The legitimate requirement of a person or organization to know, access, or possess sensitive or classified information that is critical to the performance of an authorized, assigned mission. **2.** The necessity for access to, or knowledge or possession of, specific information required to carry out official duties.)
  - Must be renewed annually unless a specific date is inserted. (Attachment F)
-

**DH 2116 Client Consent for Fax - OPTIONAL**

- DH 3204 now has faxing as part of the consent form.
  - May be used when the applicant/client is requesting their information be faxed to another provider or to receive information from another provider.
  - A different form must be completed for each provider.
  - This form is in effect indefinitely until or unless the applicant/client revokes the form. (Attachment G)
- 

**Phone Calls**

All telephone calls in which confidential information is discussed must be made from an area that ensures confidentiality is maintained:

- Cell phones and Blackberry's are not considered secure and should not be used for confidential phone calls, unless the client consents.
  - Cell phone calls regarding confidential information must be limited to the minimum information.
  - The call recipient must be informed the call is taking place on a cell phone.
  - Employee must determine the ID of the caller and what information may be disclosed.
- 

**Mailing**

A secured mail intake site must be used to receive incoming confidential information.

- Mailrooms and mailboxes must be secured to prevent unauthorized access to incoming and outgoing mail.
  - Double-enveloping is required for mailing confidential information. The outside envelope is addressed to the recipient. The inside envelope specifies confidential and the recipient name.
- 

**Faxes**

Confidential information may be faxed in a medical emergency or with written consent of the client.

- Fax machine must be in a secured area.
  - Fax Cover Sheets must have the appropriate language and state "Confidential." This language should state ***"this transmission may contain material that is confidential under Federal law and Florida Statutes and is intended to be delivered to only the named addressee. Unauthorized use of this information may be a violation of criminal statutes. If this information is received by anyone other than the named addressee, the recipient shall immediately notify the sender at the address or telephone number above and obtain instructions as to the disposal thereof. Under no circumstances shall the material be shared, retained or copied by anyone other than the named addressee."***
  - Medical information that is faxed must have a permanent copy in the record and documentation in the progress notes.
-

**Email**

- Applicants/clients wishing to use email must sign DH 3204 (or similar form) and specify the email address.
  - The applicant/client should be informed that email is not secure.
  - Information given in an email should be generic in nature and limited, even with consent from the applicant/client. Example: "This is an appointment reminder for May 27<sup>th</sup> at 8:00 a.m." Information specific to HIV/AIDS or other medical information should be given by alternate methods.
  - Email as a method of communication is at the discretion of each agency regardless of a consent form. The agency's policies and procedures manual should provide guidance to local limitations regarding email.
- 

**Field Security**

Job descriptions must document the authority to transport confidential information into the field. In addition:

- All confidential information taken into the field must be tracked, including who, what, when, why, and expected date of return.
  - Information taken into the field is limited to what is needed to perform responsibilities.
  - Prior permission must be obtained, if information is not to be returned by close of business.
  - Information must be safeguarded from unauthorized access.
- 

**Work Space**

- Eligibility staff must be provided with office space, which allows business to be conducted in a timely and confidential manner.
  - If private office space with a door is not available, the provider must ensure all communications remain confidential.
- 

**Storage**

- Offices and staff must maintain confidentiality of all data, files, and records including client records related to the services and shall comply with state and federal laws, including, but not limited to, sections 384.29, 392.65 and 455.667, Florida Statutes.
  - Appropriate storage systems for hard copy client records are required.
  - Storage systems include, at a minimum, file folders and maintained in locked file cabinets.
- 

**Client File Retention**

- File retention must follow the Department of State, Bureau of Archives and Records Management storage and disposition procedures as mandated in Florida Statute Chapters 119 and 257.
  - File retention schedule for agencies contracted with the DOH is five years from the date of termination of a provider (contract) with the DOH, or closure of the file.
-

- Upon completion or termination of the contract and at the request of the DOH, the provider will cooperate with the department to facilitate the duplication and transfer of any said records or documents during the required retention period.
  - In the event that a client file is closed the file is retained at the agency for the minimum five years before disposing of said record.
  - Shredding of documents is the preferable method of disposal.
- 

**Electronic Files and Computers**

The use of electronic files to gather and collect client information requires specific precautions to avoid a breach of confidentiality and protect the client's right to privacy. DOHP 50-10-07 includes but is not limited to the following guidance concerning electronic files and information:

- Computer monitors must be positioned to prevent unauthorized viewing.
  - All computers including laptops that access and store confidential information must be password protected and the data must be encrypted in accordance with Department of Health Information Security policies, protocols and procedures.
  - Laptops may be used for storing and accessing HIV/AIDS information with client identifiers if they adhere to the specific requirements in, DOHP 50-10-07.
  - Laptops containing confidential information must be returned to the secured area at the end of the working day and never stored in an unsecured, unauthorized area. This directive includes storing laptops in the employee's car, car trunk or home unless there is prior supervisory approval.
  - Deleting files from a computer hard drive is not necessarily sufficient if the computer is to be stored. Hard drives must be wiped. If you are unsure how to do this or what it means, consult with your IT staff.
- 

**Additional Information**

- Agencies need to document which positions have "need to know" access in their written job descriptions.
  - Unauthorized persons shall not be left unattended in areas where confidential or sensitive information is maintained.
  - All visitors must sign in on a security log.
-



## SECTION 3: Eligibility Personnel

This section describes personnel activities, responsibilities, training and documentation required for eligibility staff.

---

### Eligibility Staff

Eligibility staff is authorized by the Department of Health to determine eligibility for the HIV/AIDS Patient Care Programs and must have strong administrative, interviewing and communication skills to ensure an applicant has been appropriately determined eligible or ineligible.

---

### Supervisory Oversight

All eligibility staff must have an immediate supervisor for oversight of the eligibility process. Eligibility staff must have access to supervisors to ensure the final determination is fairly completed in accordance with the established procedures.

---

### Supervisor Responsibilities

Supervisor responsibilities include, but are not limited to the following:

- Provide oversight to the overall eligibility process including exceptions requests.
- Provide an interim supervisor when on leave or a when a position is vacant.
- Monitor staff performance and complete annual performance evaluations.

---

### Staff Responsibilities

Responsibilities of eligibility staff include, but are not limited to the following:

- Determine and re-determine eligibility in conjunction with this procedures manual and Chapter 64D-4 F.A.C.
- Maintain orderly files, document all activities relating to the eligibility process and provide accurate information.
- Provide referrals for services as appropriate.
- Prepare and participate in fair hearings (Administrative Hearings) as necessary.
- Have knowledge of federal, state and other local programs in which to refer applicants/clients.

**PLEASE NOTE:** Many county health departments and case management agencies have blended staff responsibilities to include eligibility and case management for more than one program, such as State HOPWA, AICP, Consortia and/or PAC. However, all staff completing an eligibility function must follow the established procedures in this manual and must distinguish between the roles as eligibility staff or case manager of the other program.

**Training  
Requirements**

Eligibility staff, including supervisors, must complete the Department of Health Determining Eligibility Training. A Certificate of Attendance must be maintained in the personnel file. Training schedules are posted on the Bureau of HIV/AIDS web page.

---

## SECTION 4: Eligibility Requirements

Following are the eligibility requirements for all applicants seeking services for HIV/AIDS programs under Chapter 64D-4 including Consortia, ADAP, AICP and State HOPWA.

---

**Who may apply for services?**

Any individual seeking services or their court appointed representative, legal representative, or legal guardian.

---

**Minors seeking services**

Minors may receive HIV/AIDS services without parental consent or notification in accordance with chapter 384.30, Florida Statutes.

---

**Eligibility Requirements**

The following are the requirements that must be met for all applicants seeking services under Chapter 64D-4:

- Proof of HIV
- Living in Florida
- Not participating in local, state or federal programs (such as Medicaid) where the same type of service is provided or available
- Low Income which means
  - Gross income less than or equal to 400% of Federal Poverty Level (unless exceptions are approved – see section 12 for details)
- Willingness to cooperate and provide truthful information

Additional information regarding each requirement can be found under the individual tabs.

**Documentation of each requirement must be in the eligibility file.**

---

**Applicants Rights**

The applicant acknowledges and agrees to the rights and responsibilities in the application, by submitting and signing the application. A summary of the rights and responsibilities is:

- To complete (to their ability) and submit an application
  - To obtain and submit the required documentation with the application
  - To request assistance if needed
  - To be truthful and cooperative with eligibility staff
  - To understand the Rights and Responsibilities as listed on the application and signified by signature
-



## SECTION 5: New and Re-Determination

This section describes the activities for initial determination of a new applicant and re-determination every six months or sooner as necessary.

---

### Initial Contact

Initial contact procedures may vary among eligibility providers, but each should include knowledgeable staff to provide the following minimum information:

- Eligibility requirements as stated in the brochure.
- Where to obtain the brochure/application.
- Application options to complete prior to or during the face-to-face eligibility interview with or without staff assistance.
- What services are available from programs under 64D-4.
- Time limits.

The application (Attachment H) requests general information from the applicant which could be obtained during the initial contact.

- Eligibility providers may have their own initial contact information sheet and procedures for obtaining initial information which can serve as a pre-screening tool for an eligibility office.
- Confidentiality issues could be a factor if other individuals in the applicant's household are unaware of the HIV status. It is very important to contact an applicant only in the manner instructed on Part 2 living arrangements, of the application.
- Not all eligibility inquiries will result in the applicant initiating the eligibility process.
- Initial determination must not occur for applicants who do not need to access services under the Bureau of HIV/AIDS Patient Care Programs.
- The Applicant's Financial Survey (Attachment I) may also be used as a pre-screening tool. **This form is optional.**

---

### Determination of Eligibility

An applicant's first contact with the eligibility office or process may be:

- The brochure/application itself which is available at county health departments and local HIV/AIDS community based organizations.
  - A referral from another social service program.
  - A referral from the toll-free number or AIDS Hotline.
  - An inquiry by mail or telephone.
  - A walk-in to the eligibility office.
  - A referral from a friend or another applicant.
-

**Application Requirement**

Eligibility staff must have a face-to-face encounter with the applicant to process the application, unless circumstances prevent face-to-face contact. Such circumstances must be documented in the applicant's file with supervisory oversight.

---

**Time Limits**

The eligibility rule establishes a time standard for processing the application.

- The applications must be processed and a determination of eligibility made within 30 days from the date the application was received/dated.
  - Mail-in applications are dated when received at the eligibility provider.
  - Walk-in applicants who submit a completed or partially completed application will have their application dated the same day.
  - The time-limit can be extended, with supervisory approval and documentation, if the requested information has not been received and delays the 30-day time standard.
- 

**Eligibility Staff Assessment Worksheet**

The Eligibility Staff Assessment Worksheet (Attachment J) is **required** for all initial determinations. The form must be:

- Included in each applicant's eligibility file.
  - Utilized to ensure all eligibility requirements are included and are presented in the same chronological order as required.
  - Utilized by supervisors or other local staff when a request for an exception is initiated.
  - Utilized in preparation for a Fair Hearing.
- 

**Required Documentation In Eligibility Chart**

The following documentation must be included in the file:

- Eligibility application signed and dated by applicant (original)
  - Completed Financial Assessment Worksheet
  - Proof of HIV
  - Living in Florida
  - Documented Income
  - Copies of any third party insurance (Medicaid, private, etc)
  - Releases of Information as appropriate
  - Case note documentation
  - Exception request (if applicable)
- 

**Re-Determination**

- Clients must be re-determined for eligibility at least every six months or sooner if circumstances have changed.
  - Clients will need to provide current information especially as it relates to changes in income.
  - Eligibility staff must use the Six Month Re-Certification Review Form (Attachment K) to complete re-certification.
-

- Information already in the file that has not changed does not need to be collected again.
  - Re-determination should not be performed for applicants who do not need services under the Bureau of HIV/AIDS Patient Care Programs. Applicants may return at any point for eligibility determination when services are needed.
  - A Notice of Eligibility or Ineligibility must be provided.
- 

**Appointment Reminders**

Eligibility providers are encouraged to provide appointment reminders for clients at least 2 weeks prior to the scheduled re-determination time.

---

**Redetermination Documentation Procedures**

Redetermination of eligibility has minor modifications from the initial eligibility determination process and include:

- Six Month Review Re-Certification Review Form (SSR) provides documentation of no change or identifies changes that have occurred.
  - Following the completion of the form (SSR) and any other necessary documentation, one of the following are issued:
    1. Notice of Eligibility (Attachment L)
    2. Notice of Ineligibility (Attachment M) and Notice of Rights (Attachment N)
- 

**Location of Eligibility File**

- Only one eligibility/re-determination file per applicant/client is required.
  - Each area must develop a policy to include a process for transferring a copy of the original eligibility file in accordance with all confidentiality procedures, if re-determination is completed by a different individual/agency.
  - A list of individuals/agencies responsible for eligibility and re-determination must be provided to the Contract Manager and made available to all area providers and updated as needed.
  - Eligibility and re-determination lists must be updated at least annually.
-



## SECTION 6: Eligibility Brochure/Application

The official application for all HIV/AIDS Patient Care Programs is the Application and Eligibility Requirements (#DH 150-884, 1/07), which is incorporated by reference in the eligibility rule. (Attachment H)

This official application is part brochure – part application and includes information relating to the eligibility requirements for the HIV/AIDS Patient Care Programs and is the only application accepted for purposes of determining eligibility. The brochure/applications are available at every county health department and can be made available at other local venues, such as lead agencies, case management agencies and community based organizations. The back of the application provides space for local addresses and phone numbers.

---

### Brochure

The brochure is in a question and answer format and provides the following information:

- Eligibility requirements
- Eligibility process
- Programs and services covered and not covered
- Rights and Responsibilities
- Enrollment requirements for ADAP, AICP and HOPWA
- Applicant's recourse if determined ineligible

---

### Application

The Application to Receive Allowable Services for HIV/AIDS Patient Care Programs is divided into the following sections:

- Adult Applicant Information/HIV Documentation
- Living Arrangement
- Medicaid Insurance and Other Programs
- Household Monthly Income
- Cash and Items of Value
- Right and Responsibilities
- Last Section "For Eligibility Staff Only"

---

### Rights and Responsibilities

- An applicant must be willing to cooperate during the eligibility process by signing and complying with the Rights and Responsibilities established in the application.
  - If the applicant will not sign the application, staff must not proceed with the eligibility determination process.
-

**Completing the Application**

- The application is necessary for the face-to-face eligibility interview.
  - The brochure/application can be completed by the applicant or designee during the eligibility interview.
  - Applicants are encouraged to complete as much of the application as possible.
- 

**Frequency**

- The application is required to be completed only once upon initial enrollment, unless the client's file has been closed for more than a year.
- 

**Pregnancy**

A "YES" response on the application provides an opportunity to address the specific programs earmarked for HIV-infected pregnant women. Pregnancy status is extremely important for referral purposes or to determine if the applicant is already receiving medical services. An applicant who is participating in any of the following programs (except TOPWA) will automatically meet the income requirements if they can produce the appropriate documentation:

- Children's Medical Services (CMS)
  - WIC (Women, Infants and Children)
  - Healthy Start
- 

**Housing**

A "YES" response on the application indicates a housing need which is clarified during the scheduled interview to determine the extent of a housing need for the applicant and whether or not a referral to HOPWA is indicated.

- An applicant must be determined eligible to be referred to State HOPWA. (See section 11, page 7 for further details)
- 

**Prescriptions**

A "YES" response to prescription drugs requires clarification to determine if the applicant is taking prescription drugs and extremely important for referral purposes or to determine if the applicant is already receiving medical services.

- Applicants may not be able to name their prescriptions and should be advised to bring in the prescriptions.
  - An applicant must be determined eligible to be referred to ADAP.
- 

**Interpreters/  
Illiteracy/  
Illness**

- The brochure portion is available in English, Spanish and Creole, with the connecting application portion in English only.
  - Eligibility providers should be available to assist persons unable to read, and eligibility offices are responsible for obtaining interpreters, as applicable.
-

## SECTION 7: Proof of HIV

An applicant must have documentation of a medical diagnosis of HIV disease with a laboratory test documenting confirmed HIV infection.

---

### Acceptable Proof

One of the following is considered acceptable proof:

- A confirmed positive HIV antibody test result (Reactive EIA/ELISA screening test) confirmed by Western Blot or Immunofluorescence Assay (IFA) or Nucleic Acid Testing (Aptima) by blood, oral fluid or urine.
- A positive HIV direct viral test such as PCR or P24 antigen.
- A positive viral culture result.
- A detectable HIV-viral load or viral resistance test result.

---

### Information

- A copy of the Florida state lab DH Form 1648C is the most common form of documentation of an applicant's HIV+ test result.
- The laboratory interpretation section of the on page form will indicate the HIV+ Western Blot or Elisa/Western Blot confirmed or OraSure/Western Blot confirmed.

---

### Types of Labs Accepted

- The Western Blot is a blood test and the most common confirmatory test identified on the state lab and other lab test results.
- The Elisa blood test commonly referred to as EIA (Enzyme Immunoassay) must be confirmed by a Western Blot.
- OraSure is FDA approved as a diagnostic test, including both screening and Western Blot confirmation. This test is acceptable for purposes of eligibility.

---

### Exposed Infants

- Exposed infants of HIV positive mothers can be served with documentation of the mother's HIV positive status up to the age of 36 months.
- Children 36 months or older must meet the same criteria for proof of HIV as listed above to continue services.

---

### Not Acceptable Proof

- A physician's or nurse's statement of HIV positive status on a prescription or letterhead.
  - Oraquick.
  - Project AIDS Care (PAC) physician's referral.
-



## SECTION 8: Living in Florida

An applicant must be living in Florida.

---

### Living in Florida Definition

- For purposes of eligibility, living in Florida refers to applicants who make Florida their home.
- A specific number of weeks or months in Florida are not required to be considered living in Florida; however, an applicant's intent to remain in Florida is of interest to the HIV/AIDS Patient Care Programs, particularly for medical and treatment services.
- Applicants can have unusual circumstances, such as the unpredictability of migrant work, which require consideration.
- Eligibility providers should solicit more information as needed.

---

### Documentation

Documentation to verify an applicant's identification include:

#### **One Photo Identification**, (not required but encouraged)

- driver's license
- passport
- school ID
- other state or local Florida photo identification

Other forms of applicant's identification include (but are not limited to):

- Utility Bill, with name and address
- Housing, Rent/Mortgage Agreement
- Recent School Record
- Letter from person with whom the applicant resides
- Homeless Shelter/Social Service Agency letter signed by staff
- Property Tax Receipt or W-2 form for previous year
- Unemployment Document with Address
- Current Voter Registration Card
- Lawful Permanent Residency ('green card')
- US Visa – Immigrant
- US Visa – Nonimmigrant
- Prison records (if recently released)

Photo identification should not be considered the only form of identification especially if it is not current.

---

**Homeless**

Documentation can include:

- A statement from the shelter in which the applicant resides.
  - Physical observation from eligibility staff with a statement in the file.
  - A statement from a social service agency or other applicable person attesting to the homeless status of the applicant.
- 

**Winter Residence Only**

- Applicants who winter in Florida, but maintain their permanent residence in another state, should be accessing resources and making arrangements for treatment in their home state.
  - Income tax information can provide the documentation necessary to determine primary residence.
- 

**Immigration Status**

- Citizenship of the United States and immigration status are not required as a condition of eligibility for the HIV/AIDS Patient Care Programs.
  - Applicants who are undocumented/illegal aliens do not have social security numbers and are identified using alternate identification numbers.
  - Eligibility providers are not required to report undocumented aliens to the Immigration and Naturalization Services (INS).
- 

**Use of Social Security Number**

A social security number is not required for eligibility determination but is required for some programs such as ADAP. Eligibility staff may collect the social security number. If documenting an alternate social security number, this can only be done under the following circumstances:

- Undocumented aliens.
  - Non-citizen residents who do not have a Social Security Number.
  - Children under age 1 who do not have a Social Security Number.
- 

**Creating Alternate Identification Numbers**

If staff must create an alternate identification number, they must use the following format for consistency among all programs under Chapter 64D-4.

- First letter of client's first name, followed by
- First letter of client's middle name or "X" for persons with no middle name, followed by
- First letter of client's last name, followed by
- Client's six digit date of birth (MM-DD-YY)

Example: If a client's name is Joe Edward Smith and he was born October 5, 1945, his Alternate Identification Number would be JES100545.

---

## SECTION 9: Screening for Other Programs

Screening for other available programs is a required step in the eligibility process. Determining whether an applicant/client is already participating in local, state or federal programs is necessary to eliminate duplication of services and to adhere to federal requirements associated with the funding of the programs.

This section provides information relating to specific circumstances which may arise during the applicant interview for this requirement.

---

### **Payer of Last Resort**

An applicant may not be eligible for services from the HIV/AIDS Patient Care Programs if the applicant is already receiving or is eligible for the same benefits/services from other programs. The services provided by Ryan White Part B and the other HIV Patient Care Programs may be utilized for HIV related services only when no other source of payment exists.

An applicant cannot be receiving services or be eligible to participate in local, state or federal programs where the same type service is provided or available. This requirement does not preclude an individual from receiving allowable services not provided or available by other local, state or federal programs, or pending a determination of eligibility from other local, state or federal programs.

**Exception:** HRSA has allowed an exception for those persons able to access the Veterans Administration. See further details under VA below.

---

### **Other Federal, State and Local Programs**

Eligibility providers must be familiar with the other federal, state and local assistance programs providing HIV/AIDS services for persons in Florida. A brief description of some common programs include the following:

---

### **Medicaid**

Medicaid is a state and federally funded entitlement program. The Department of Children and Families and/or the Social Security Administration determine Medicaid recipient eligibility. Some categories of people who might be eligible for Medicaid include:

- Single parent household with children under age 18
- Two parent household unemployed or underemployed
- Disabled individuals by SSA or DCF determination.

Most applicants who are Medicaid eligible will not be eligible for HIV/AIDS Patient Care Programs as these services are covered by Medicaid. If the services are not covered, these persons will still need to be determined eligible to access other HIV/AIDS Patient Care Services.

---

**Medicaid Screening**

All clients that may be eligible for Medicaid benefits should be prescreened for Medicaid eligibility.

Procedure for Prescreening Clients

1. Visit the following link <http://www.myflorida.com/accessflorida/>
2. Click on “[Medicaid Pre-Screening Tool](#)” link
3. Complete the form and click the “[Continue](#)” button
4. Verify the information and click the “[Continue](#)” button

If the Medicaid Pre-Screening Tool determines the client is possibly eligible for Medicaid Services the applicant/client must apply for Medicaid.

---

**Medicare**

- Federal funded entitlement program administered by the Centers for Medicare and Medicaid Services. (CMS)
  - Health insurance for people age 65 or older, under age 65 with certain disabilities, and any age with End-Stage Renal Disease.
  - Persons with disabilities are eligible for Medicare after two years of being determined disabled by the Social Security Administration.
  - Most people receive Medicare health coverage in one of two ways, an original Medicare plan or a Medicare Advantage plan.
  - Costs vary depending on the plan, coverage and services used
- 

**Medicare Part D**

- “Part D” is prescription drug coverage for Medicare Part A and B recipients.
  - Applicants/clients seeking assistance with HIV/AIDS Patient Care Programs, who are eligible to receive Part D, must apply through the Social Security Administration.
  - Part D recipients are required to select a drug plan.
  - Monthly premium costs vary depending on the plan selected.
  - There are two ways to get Medicare prescription drug coverage:
    - Join a Medicare prescription drug plan that adds drug coverage to the original Medicare Plan, or;
    - Join a Medicare plan (like an HMO) that includes prescription drug coverage as part of the plan.
  - Clients accessing Part D do not need to spend down pharmaceutical benefits prior to enrolling in ADAP; however, applicants/clients must apply for the low income subsidy.
- 

**Low Income Subsidy (Extra Help)**

- Medicare beneficiaries who have limited income and resources may qualify for extra help to pay for prescription drugs costs.
  - This low-income subsidy from Medicare provides financial assistance for beneficiaries who have limited income and resources.
-

- Those who are eligible for this low-income subsidy will get help paying for their monthly premium, yearly deductible, prescription coinsurance and co-payments and no gap in coverage.
  - Some people are automatically eligible for the low-income subsidy. Those include people who are: full benefit dual eligibles; SSI recipients with Medicare; Medicare Savings Programs participants.
  - Some people must apply through SSA.
- 

**Patient Assistance Programs (PAP's)**

- Patient Assistance Programs are available through pharmaceutical companies for free medications to people who can't afford to buy their medicine.
  - Qualification guidelines vary among pharmaceutical companies.
- 

**Expanded Access Programs (EAP's)**

- Expanded Access Programs provide life saving drugs still in clinical trials to people who need access to them immediately. The Food and Drug Administration (FDA) has established medical criteria for enrollment. The drugs are provided free of charge and are available to patients through participating physicians.
  - Applicants seeking assistance through EAP's should communicate with their physician.
- 

**Medicaid Project AIDS Care (PAC) Waiver Program**

- Medicaid Project AIDS Care (PAC) Waiver program is a home and community-based program including a wide range of authorized services for clients.
  - Must have a medical diagnosis of AIDS and be determined disabled according to the Social Security Administration and income less than 200% FPL.
  - All clients participating in the PAC program have a case manager.
  - PAC case managers are the primary and lead case managers and are responsible for accessing Ryan White Part B or other services.
  - Documentation of PAC participation waives the income eligibility requirement. (Income still must be reported for ADAP, see section 11)
- 

**Prescription Discount Card Program**

- This plan is not insurance; it is a prescription discount program.
  - The card provides immediate discounts at the pharmacy. Upon presenting your card to the pharmacist, you will pay the lower of a discounted price or the pharmacy's regular retail price.
  - There are no claim forms to fill out and no limit to the number of times you can use the card. These discounts are available only at participating retail pharmacies.
  - Apply online at <http://www2.caremark.com/naco/index.htm>.
-

**Temporary Assistance To Needy Families (TANF)**

- TANF was previously Aid to Families with Dependent Children (AFDC)
  - The purpose of TANF is to:
    - Provide assistance to needy families with children so that they can live in their own home or the homes of relatives;
    - End the dependency of needy parents on government benefits through work, job preparation, and marriage;
    - Reduce the incidence of out-of-wedlock pregnancies; and
    - Promote the formation and maintenance of two-parent families.
  - Applicants can apply for TANF through the Florida Department of Children and Families.
- 

**Food Stamps**

- Food stamp benefits are intended to supplement other household income and may only be used to purchase food. Other household items such as cleaning supplies, paper goods, clothes, and alcohol or tobacco products may not be purchased with food stamps.
  - Anyone can apply for food stamps. To get food stamps, a household must meet certain conditions. Everyone who is applying in the household must have or apply for a Social Security number and be either a U.S. citizen, U.S. national or have status as a qualified alien.
  - All those applying for or receiving SSI payments, must take or send their food stamp applications to the local food stamp office or to any Social Security office where a food stamp representative works.
  - When interviewed, an applicant should have:
    - Identification such as a driver's license, state ID, birth certificate or alien card;
    - Proof of income such as pay stubs, Social Security, SSI, or a pension for each member of your household;
    - Proof of how much you spend for child care;
    - Rent receipts or proof of your mortgage payments
    - Records of your utility costs; and
    - Medical bills for those members of your household age 60 or older, and for those who receive government payments such as Social Security or SSI because they are disabled.
  - Proof of applicants receiving food stamps waives the income eligibility requirement. (Income is still required for ADAP, see section 11)
- 

**Veterans Administration (VA)**

- The Florida Department of Veteran's Affairs is a state agency created to assist all former members of the Armed Forces of the United States and their dependents in preparing claims for and securing compensation, hospitalization, and other medical benefits for eligible persons.
  - Veterans will be issued documentation of VA eligibility or denial.
  - Pending enrollment in the VA programs, eligible applicants may receive services through the HIV/AIDS Patient Care programs until VA services are available.
-

- Enrollment in VA services is not required in order to be eligible for services funded by the HIV/AIDS Patient Care Programs. However, VA services provide comprehensive health care coverage for veterans while the HIV/AIDS Patient Care Programs only provide coverage for HIV related services.
- 

**Children’s Medical Services**

- The Children’s Medical Services (CMS) program provides children with special health care needs with a family centered, managed system of care.
  - Children with special health care needs are those children under age 21 whose serious or chronic physical, developmental, behavioral or emotional conditions require extensive preventive and maintenance care beyond that required by typically healthy children.
  - CMS provides a comprehensive continuum of medical and supporting services to medically and financially eligible children and high-risk pregnant women.
  - The continuum of care includes prevention and early intervention programs, primary care, medical and therapeutic specialty care and long-term care.
  - Services are provided through an integrated statewide system that includes local, regional, and tertiary care facilities and providers.
- 

**KidCare**

Florida KidCare is the state’s children’s health insurance program for uninsured children under age 19. It includes four different parts, or programs (MediKids, Healthy Kids, Children’s Medical Services, and Medicaid). When you apply, Florida KidCare will check which program your child may be eligible for based on age and family income. Some of the services Florida KidCare covers are:

- Doctor visits, check-ups, shots, hospital and surgery
  - Prescriptions
  - Emergencies
  - Vision and hearing, dental and, mental health
- 

**Local Assistance Programs**

- Local indigent programs which have requirements more restrictive than the HIV/AIDS Patient Care Programs.
  - If the income requirement for the local indigent care program is at or below 400% FPL, the HIV/AIDS patient Care program’s income requirement may be waived.
  - Documentation of the local program income requirement and participation in the program are required.
-



## SECTION 10: Health Insurance

An applicant must access health insurance coverage when and if available.

### Adequate Health Insurance

- Applicants with health insurance available from an employer or other private insurance must apply for and access the offered health insurance, if it has been assessed the policy has adequate coverage.
- Services from the HIV/AIDS Patient Care Programs will only be considered under the following circumstances:
  - insurance is inadequate,
  - does not cover required medical care or pharmaceuticals, or
  - the co-pays or premiums are too costly for the applicant
- If assistance is needed in determining if a policy is viable, staff can contact the Health Council of South Florida at (305)592-1452, ext 121, or the local AICP provider.

Applicants who meet the other eligibility requirements may be served pending a final assessment of the insurance policy, if the circumstances are warranted. Seek supervisor approval under these circumstances.

---

### Co-Pays and Premiums

Once determined eligible, if the applicants/clients insurance policy is assessed to have partial coverage or full coverage but co-pays, deductibles and premiums are too high for the applicant, staff should:

- Determine if the applicant/client is eligible for AICP and refer to the local AICP provider for enrollment.
- Assist with deductibles, co-pays and premiums where necessary through local Part B or other dollars until applicant/client is enrolled in AICP.
- Once enrolled in the AICP, enroll applicant/client into the special services program (which is part of AICP), if available.

---

### Electing Not To Use

- If an applicant has an adequate employer-sponsored-insurance but has elected NOT to use it (for whatever reason), the applicant must be advised of the restrictions with public funding and that this is not an option.
  - Applicants who still choose not to utilize their insurance must be given a Notice of Ineligibility (since Patient Care programs are payor of last resort).
  - Exception: minors covered by their parents insurance can be waived from accessing the insurance due to the confidentially issues.
-

**Pre-Existing Conditions and Waiting Periods**

- Some insurance policies have pre existing conditions that do not allow access for 6-12 months from enrollment.
  - Some insurance coverage terms have 30 - 90 waiting periods before benefits begin. Pharmacy coverage is most commonly delayed for many plans.
  - Applicants must enroll for insurance coverage even under these circumstances.
  - Eligibility staff should then complete Attachment O, Insurance Waiver Form, which identifies the time frame the applicant, will be able to use their insurance.
  - Applicants may then be eligible for ADAP and consortia services until such time their insurance can be used.
- 

**AIDS Insurance Continuation Program (AICP)**

Always check with AICP to keep the requirements referenced in this section updated and current. Although determining program qualifications for AICP is not a part of the eligibility process, eligibility staff may want to advise an applicant if they do not qualify for the AICP due to programmatic qualifications.

The AICP assists with co-pays, deductibles and premiums as needed and available. To be referred to the AICP an applicant must:

- Be determined eligible for HIV/AIDS Patient Care Programs.
  - Have a current health insurance policy with premiums less than \$750.
  - Be willing to participate in the AICP by providing their health insurance benefits package and explanation of benefits.
- 

**Screening for Health Insurance**

The following steps should be taken during the Eligibility process to screen for health insurance:

**Step 1 Initial determination**

Ask the applicant/client if they currently have health insurance, or determine if they are working for a company that offers health insurance.

**Step 2A If Yes:**

- Obtain a copy of the insurance card and policy coverage (maintain copy in eligibility file).
  - Determine if the coverage is viable including pharmaceutical coverage. (seek assistance from AICP staff or the lead agency staff if help is needed with this effort).
  - Determine the premium cost to the applicant/client and if help is needed with their portion to maintain coverage (not everyone needs assistance with premium payments).
  - If assistance with premium payments is needed, refer the client (once
-

determined eligible) to the AICP provider.

**Step 2B If No:**

- Determine if the applicant is employed.
- If no, document as the applicant/client likely has no insurance or access to insurance. Proceed with Eligibility.
- If yes, the client will need to provide proof of no access to insurance from their employer. This can be done in many ways.

Examples:

- Letter from employer.
- Personnel handbook which describes benefits.

(NOTE: It is not acceptable to take a client's word they have no access to insurance when employed).

- If the client has no access to insurance, keep documentation in file and proceed with Eligibility.
- If the client has access to health insurance, take the following steps:
  - Determine if they already have insurance and follow step 2 above.
  - Determine if the client has access to insurance and when it is available (usually there is an open enrollment period).
  - If open enrollment is not immediate, complete the Insurance Waiver Form (Attachment O) stating they will have to access insurance during open enrollment but they can be determined eligible until open enrollment. Refusal to access insurance is reason for denial of eligibility. Bureau of HIV/AIDS programs are payer of last resort. There are some unusual circumstances which are described below under Exceptions and Waivers.
  - Under this circumstance, keep documentation of open enrollment and proceed with Eligibility. Document on the bottom of the Notice of Eligibility when the client will have access to private insurance.
  - During open enrollment, the applicant/client must access insurance and follow step 2 above.

**Step 3 Exceptions/Waivers/Miscellaneous Information**

- Insurance policies with poor pharmaceuticals coverage and/or high out of pocket costs may be eligible for a waiver from ADAP.
  - Applicants/clients who are in the process of completing COBRA may have a lapse in coverage for a period of 30-60 days. Application for COBRA should be completed as soon as possible (they have no more than 63 days).
  - Local consortia dollars may be utilized to pay for the drugs in the interim. ADAP does not provide interim drug coverage.
  - Interim coverage for a premium payment (and does not need to apply for AICP), may be accessed through Part B in the health insurance line item. Please contact your lead agency for more information.
-



## SECTION 11: Income

The HIV/AIDS Patient Care Program's income eligibility requirement is defined as:

- A gross household income (before taxes and deductions) at or below 400% of the Federal Poverty Level (FPL).

---

### Federal Poverty Guidelines

The Federal Poverty Guidelines provide a measure of poverty. They are updated annually in the Federal Register by Health and Human Services (HHS). The guidelines are a simplification of the poverty thresholds when determining financial eligibility for certain Federal programs. For general questions about the Federal Poverty Level (FPL), visit the Internet site at <http://aspe.hhs.gov/poverty>

The FPL is utilized by the HIV/AIDS patient Care Program's to determine the maximum amount of income allowed for eligibility.

The following FPL charts are made available on the HIV/AIDS Patient Care Website as follows and are updated annually:

HIV/AIDS Patient Care Monthly FPL Chart (400%) (Attachment P)  
HIV/AIDS Patient Care Annual FPL Chart (400%) (Attachment Q)

---

### Determining Income Waiver

An applicant is automatically income eligible, if he/she can provide the certification or proof of eligibility for one of the following programs: (Current documentation less than six months old is required)

- Medicaid (not Medically Needy)
- Medicaid Project AIDS Care (PAC) Waiver Program
- Food Stamps
- Supplemental Security Income (SSI)
- Special Low Income Medicare Beneficiary (SLIMB)
- Qualified Medicare Beneficiary (QMB)
- Qualified Individual (QI-1)
- Low Income Subsidy –Extra Help (LIS)
- Temporary Assistance for Needy Families (TANF)
- WIC (Women, Infant and Children)
- Local indigent programs

A copy of the Medicaid card is only acceptable as proof when it is validated that it is current. (Ex: MEVSNET, FMMIS)

For a comprehensive list of SSI-related programs available in Florida, visit internet site at <http://www.dcf.state.fl.us/ess/ssifactsheet.pdf>

---

If the applicant meets the requirements to waive the income:

- A copy of the card or confirmation letter on the agency's letterhead or other certification or proof of eligibility is filed with the applicant's record.
- Documentation for the waiver is completed on the Financial Worksheet.
- The final determination of eligibility is based on compliance with the other eligibility requirements.

If the Applicant does not meet the waiver requirements, eligibility providers will proceed to the next step, Determining the Household Size.

**Self disclosure – Some of the HIV/AIDS Patient Care programs (such as ADAP) require income information. If documentation under this circumstance does not include income, the applicant/client must self disclose this information. This will be necessary for the Notice of Eligibility. Entering zero income for those applicants with an income is not an option.**

---

**Gross Income  
versus Net Income**

Gross income is commonly defined as the amount of a company's or a person's income before all deductions of any taxpayer's income, except that which is specifically excluded by the Internal Revenue Service, before taking deductions or taxes into account. Section 61 of the Internal Revenue Code defines "gross income" as "all income from whatever source derived".

Net income for an individual, gross income minus taxes, allowances and deductions. An individual's net income is used to determine how much income tax is owed.

- In business, what remains after subtracting all the costs (namely, business, depreciation, interest, and taxes) from a company's revenues. Net income is sometimes called the bottom line, also called earnings or net profit.

**Gross income is the amount used when determining eligibility except in the cases where the applicant/client reports self-employment.**

---

**Earned Income,  
Unearned Income  
and Deemed  
Income**

Earned Income is compensation earned from participation in a business, including wages, salary, tips, commissions, and bonuses, earnings from self-employment and royalties or honoraria.

Unearned Income is all income that is not earned, such as Social Security benefits, pensions, state disability payments, unemployment benefits, interest income, property rental income and cash contributions from friends and relatives.

Deemed Income is all earned and unearned income from the applicant's spouse, if married and from the adults living in the home who are counted in the household size.

---

---

**Step 1  
Determining  
Household Size**

A household is a domestic establishment which includes the applicant, members of his/her family and others who live under the same roof. The size of the household used in determining the applicant's FPL will not necessarily include everyone in the home.

**Counted**

Only specific individuals are counted when determining the household size for purposes of determining the applicant's FPL. Those counted in the "household size" are:

- Applicants (always)
- Spouses (always, if married)
- Applicant's children (always if minors)
- Adults, such as parents, adult siblings, adult children, significant others and partners who live with the applicant in his/her home and meet one or more of the following:
  - Claims the applicant as a dependent on a tax return
  - Claims the applicant on a health insurance policy.
  - Has legal custody or other legal arrangement or guardianship of the applicant.
  - Has commingled financial arrangements to the extent that the banking, savings, business, mortgage agreement and other personal finances are indistinguishable.

---

**Not Counted**

Not counted in "household size" are:

- Roommate(s) with separate finances who share only in the cost of room and board. (Room and board includes household expenses such as utility, cable, phone, rent or mortgage and meals).
- Adults such as parents, adult siblings, adult children, significant others and partners who live with the applicant but have separate finances and/or share only household expenses.
- Adults such as parents, adult siblings, adult children, significant others and partners who do not live in the same home with the applicant but share commingled financial accounts or provide a monetary contribution to the applicant (daily, weekly, monthly, annually etc.).
- Live-in aides who receive payment for their services.
- Children who are not financially dependent of the applicant.

---

**Commingled Funds**

- Commingled funds are defined as a blending or mixing of financial accounts such as checking, savings, mortgage, insurance policies or employment benefits.
  - When there are joint accounts with both names giving each person access to the account, it is considered commingled funds.
-

**Step 2  
Determining  
Household Income**

- Household Income is defined as income received by the applicant from all sources.
  - Adults living outside of the household who provide money to the applicant on a daily, weekly or monthly basis are not included in the household size, but amount of financial support (allowance) is counted and documented on the worksheet under “other sources of income.”
  - Income includes items which generate funds and may be counted as income. *For example, a second home rented out generates income.*
  - A list of items counted as income is included on the worksheet.
- 

**Income Counted  
(including  
documentation)**

The total amount of income from all counted household members are calculated on a monthly or annual basis, but not both, and include but are not limited to the following:

Earned Income:

- Pay stubs for the last three months showing income before taxes and deductions.
- A signed and dated employer statement on company letterhead stating name of applicant, rate and frequency of pay, a phone number and whether applicant is currently receiving or is eligible to receive health benefits from employer.
- 1040 form or W-2 form for previous year.
- If Self-Employed:
  - 1040 Form for previous year with corresponding attachments (Schedule C or Schedule SE)
  - W-4 forms for previous year
  - Company accounting books showing business revenue and expenses
  - Self-employment tracking sheets (extenuating circumstances may call for supervisory concurrence)

Unearned Income:

- Retirement income statement from Social Security
  - Retirement pension statement from private or public fund
  - Trust fund income
  - Military/Veteran pension benefits statement
  - A recent Third Party Query (TPQY) printout from Social Security
  - IRS 1040 Supplemental Income and Loss (Schedule E) for property rental income (net income is counted in this circumstance)
  - Unemployment benefit stubs
  - Alimony payments
  - Benefits from dependent children (i.e. survivor’s benefits)
  - Child support payments
-

- 
- Cash assistance by relatives and other individuals (included in Letter of Support)
  - Monthly Income from welfare agencies (public & private)
  - Interest on investments

Regardless of the date an applicant/client presents for eligibility determination or re-determination, three months of current (90 days prior to enrollment or reassessment) paycheck stubs allow for the income to be counted and projected forward to an annualized salary; however, flexibility can and should be taken into account if the applicant was unemployed, just started employment or is missing a few pay stubs from the three-month cycle if the applicant has the most recent and consecutive pay stubs showing YTD amounts.

---

**Self Employed  
(including  
documentation)**

Self-employment income includes but is not limited to small businesses, including proprietorships and partnerships, paid professional, paraprofessional or occupational services such as lawn care, domestic work, handyman, landscaping, farming, salesmen or royalty or honoraria from intellectual property or authorship.

Eligibility for a self-employed client is based on net income. Net income is obtained from the Federal Income Tax Return (IRS1040) and all applicable schedules and attachments:

- Schedule SE entitled Self-Employment Tax:
  - Section A, Line 4 or Section B, Line 6, as applicable
- Schedule C, entitled Profit or Loss from Business, Line 31.

If this is not available or if client has not been self-employed long enough to have filed taxes, the applicant can submit records of their monthly self-employment income for at least the past three months. Self-employment tracking sheets (Attachment R) may serve as proof of income in these cases. Extenuating circumstances may call for supervisory concurrence. In such cases, subtract from gross self-employment income any allowable business expense necessary and directly related to producing goods or services. Allowable self-employment expenses include but are not limited to:

- Purchasing inventory.
  - Space rental and utilities.
  - Salaries for employees other than the client.
  - Transportation expenses required for employment, and
  - Interest on loans for capital assets or durable goods.
  - Income reinvested in a business, except for the purchase of real estate, is an allowable business expense. This includes the purchase of capital equipment, payment on the principal of loans, and other expenses needed to produce goods and services.
-

**NOTE:** Capital equipment is equipment needed to produce self-employment goods (e.g. a printing press, copy machines, farm machinery, tools, sewing machines, tractors, tow trucks, etc.). If the expenses exceed the gross receipts, the self-employment income will be zero.

---

**No Income  
(including  
documentation)**

For no income:

- A statement is provided as to how the applicant receives food, clothing and shelter, also known as a letter of support.
- A recent Summary Earnings Query (SEQY) or Work and Gain Economic Self Sufficiency (WAGES) printout or an income tax return from the previous year
- Federal Insurance Contribution Act (FICA) will establish prior work year income.

Note: While SEQY, WAGES, FICA printouts may verify only prior-year income, such information can be useful in helping to support the factual establishment of current income or claims of no income.

- In cases where the applicant declares no income, documentation is required to validate his/her status.
- A discussion of no income and unemployment is covered, in this document, when determining the household size.

Some examples of questions to ask an applicant who has little or no income coming into the household include the following:

- How does the applicant support him/herself without income or employment?
- How are food, clothing, shelter and utilities being managed?
- How long has the applicant been unemployed?
- What is the applicant's previous work experience?
- What are the applicant's educational qualifications?
- Is the applicant underemployed? Could the applicant find better employment?
- Is the applicant currently looking for employment?
- What is the reason for unemployment (Medical, Voluntary)?
- If Medical, what is the status of Disability/SSI determination?
- If Voluntary has payer of last resort been discussed"?
- Has there been any effort to find a job?
- Is the applicant receiving Unemployment Compensation?

The above list of questions reflects subject areas which can be explored on a case-by-case basis. Not all questions will be applicable.

---

**Income Not Counted**


---

Income which is not counted includes loans to applicants that need to be repaid, grants, scholarships, fellowships, value of food stamps, retirement benefits, Ricky Ray Hemophilia Relief funds, and 401K if not accessed and any other non-accessible income, such as trust funds.

---

**State HOPWA Exception**

- Applicants seeking assistance from state HOPWA must be determined Eligible under Chapter 64D-4.
  - Applicants, who are not eligible based on the FPL limit, should be assessed for a housing need.
  - The state HOPWA program qualification allows applicants to be at 80% of the median income, which in some instances is less than 400% of the FPL.
  - Under these circumstances, if all other criteria except FPL are met, applicants who might have a housing need should be given a Notice of Eligibility with a notation for **HOPWA only** and referred to the HOPWA program. (This step is very important)
  - Individuals receiving a Notice of Eligibility Exception for HOPWA services are not a guarantee to receive HOPWA services. Additional programmatic requirements will determine whether an individual may receive HOPWA services regardless of a Notice of Eligibility.
  - The state HOPWA program will assess for 80% of the median income.
  - Not all applicants who seek eligibility will have a housing need.
- 

**Refusal to Divulge**

- Applicants who refuse to divulge or document income will not be able to complete the financial eligibility assessment and will therefore be determined ineligible.
  - This includes spouses and household members counted in the household size who refuse to provide the appropriate information.
  - Under these circumstances applicants/clients must be given a notice if ineligibility with an explanation.
- 

**How To Calculate Income**

Because applicants/clients get paid in differing pay cycles, calculating income can be a challenge. Below are some examples of how to calculate income. (Review income counted section for details).

**MONTHLY**

- Gross amount X 12
- Example: \$1,288.52 X 12 = \$15,462.24 (annual income)

**BI-MONTHLY (twice per month)**

- Gross amount X 24
  - Example: \$1325.28 X 24 = \$31,806.72 (annual income)
-

**BI –WEEKLY (every two weeks/26 pay checks)**

- Gross amount X 26
- Example: \$1417.92 X 26 = \$36,865.92 (annual income)

**WEEKLY**

- Gross amount X 52
- Example: \$600.32 X 52 = \$31,216.64 (annual income)

**Circumstances may vary based on the availability of documentation.**

- Year To Date (YTD) information can be used if only one pay check stub is available. Example: June 30, 2008 pay stub reflects YTD \$19,055.00 and applicant/client is paid bi-weekly. Calculate the income by dividing the YTD income by number of weeks paid to date to determine bi weekly pay and multiply by 26 pay periods to get annual income.

**EXAMPLE: \$19,055.00/13= \$1465.77x 26= \$38,110.00**

**Final Income Determination**

- The total amount of income from all counted household members is calculated on a monthly or annual basis, but not both.
- All of the earned and unearned income is documented on the worksheet, and the grand total for the household income is tallied.
- This amount cannot exceed the applicant's FPL dollar amount which is determined in step 3.

**Step 3:  
Calculating the  
Federal Poverty  
Level**

- The Federal Poverty Level should be calculated to a specific number rather than a range.
- Calculate total annual household income.
- Calculate total household size.
- Using the most current FPL chart and the household size total, calculate the FPL.
- You must use the annual income chart to arrive at the correct FPL.
- Once the FPL is determined, document this on the financial worksheet.

Example: If an applicant's income is \$24,000 annually and their spouse's income is \$22,000 annually, add the total income together. Divide the total based on a family size of two using the amount in columns A (100% FPL) to determine the specific FPL.

**\$24,000 + \$22,000= \$46,000 divided by \$14,000= 328% FPL**

## SECTION 12: Requests for Exception

The eligibility rule allows an exception to the eligibility requirements, with approval from the department or designated staff and under specific conditions. The request for an exception is not to be used as a routine practice for every applicant who fails to meet the eligibility requirements.

### Exception Criteria

The criteria for an exception are:

- To prevent the loss of health insurance benefits, or
- To prevent hospitalization, or
- To ensure continued access to medications and treatment.

In addition, a request for an exception can be granted only:

- in an emergency situation, and
- for short-term circumstance (less than 180 days).

If the applicant's circumstances do not meet the above criteria, an exception request will not be considered.

---

### Who should request an exception?

- Exceptions must be initiated by the eligibility provider, and approved by the direct supervisor.
  - Applicants can not directly request an exception.
- 

### Procedures for Requesting an Exception

If the applicant's circumstances meet all of the above exception criteria, the exception procedure which requires supervisory review are as follows:

1. Eligibility providers will submit the following documents:
    - The completed application.
    - The applicant's financial survey (if used).
    - The completed eligibility staff assessment worksheet.
    - All the required back up documentation.
    - The eligibility Request for Exception Form (Attachment S) completed in its entirety by the eligibility provider.
    - A short narrative to justify the exception.
  2. The supervisory review requires complete assessment of the exception circumstance and documentation:
    - If the supervisor does not concur there is justification for an exception, it is documented on the request form.
    - A Notice of Ineligibility and the Notice of Rights are issued to the applicant, and the ineligibility procedures are followed.
-

- If the supervisor concurs with the request for an exception, it is documented on the request form and sent to the lead agency for review.
  - If the lead agency does not concur with the exception, it is documented on the request form and sent back to the eligibility staff member to issue of Notice of Ineligibility.
  - If the lead agency concurs with the exception, it is documented on the request form and sent to the HIV/AIDS Program Coordinator (HAPC) or their designee for approval.
  - If the HAPC or designee does not concur, it is documented on the request form and sent back to the eligibility staff to issue a Notice of Ineligibility.
  - If the HAPC or designee concurs, it is documented on the request form and sent back to the eligibility staff to issue a Notice of Eligibility.
3. If the HAPC or designee require additional support:
- The HAPC or designee should call their Bureau of HIV/AIDS community program coordinator to discuss and provide technical assistance.
  - If further assistance is required the packet of information must be mailed to the Department of Health, Division of Disease Control, Bureau of HIV/AIDS, ATTN: Eligibility Review, Patient Care Program Administrator, 2585 Merchants Row Boulevard, 3<sup>rd</sup> Floor, Tallahassee, Florida 32399-1715.
  - Expect a three-day turnaround (via phone and hard-copy) from the date of receipt, unless additional information is requested.

All exceptions should take no more than 10 business days from the original request date, unless extenuating circumstances present.

**REMINDER: Exceptions must be based on the criteria and will automatically be denied if all documentation is not provided.**

---

**Tracking**

- All exceptions must be tracked by the HAPC or designee and reported to the Bureau of HIV/AIDS on a monthly basis, using the exception request log provided. (Attachment T).
  - Exceptions tracking sheets should be sent via email to the community program coordinator for the area.
-

## SECTION 13: Eligibility Determination

This section provides guidance for eligibility determination and required documentation.

### Eligibility

Eligibility determination requires the following documentation:

- The completed application.
  - The completed eligibility staff assessment worksheet.
  - The applicant's financial survey (if used).
  - All the required documentation.
- 

### Notice of Eligibility

Eligibility providers are required by rule:

- To provide an applicant with written confirmation of the eligibility determination.
- The Notice of Eligibility (Attachment L) is written confirmation required and is valid for six months.

The Notice of Eligibility includes the following:

- The re-determination date, eligibility staff, phone number, and office address.
- The FPL, income, and household size.

Staff must remind the client of their responsibility to advise the eligibility office of any circumstances which could impact their eligibility status.

---

### Referrals

The primary tasks by eligibility staff after a determination of eligibility include referrals and requires the following:

- Explain local case management services available, and that case management agencies have trained staff to provide a comprehensive client needs assessment for service linkage. Case management is not mandatory.
  - Provide the applicant a choice of case management service providers in the area (if available) and make the appropriate referral. If the staff completing the eligibility process works at a case management agency, the client is still provided a choice of case management agencies in the service area.
  - Review allowable services are based on availability, accessibility and funding of the service in the client's local area.
  - Clients who indicate insurance, housing or AIDS drug assistance needs may be referred directly to these specific single service programs, with their Notice of Eligibility as verification of eligibility.
-

**Ineligible**

- An applicant may be found ineligible at any point during the eligibility process.
- Supervisory review is required of all cases considered for ineligibility prior to issuing a Notice of Ineligibility.

To make a final determination of ineligibility, staff will review for accuracy the following documentation:

- The completed application.
  - The applicant's financial survey (if used).
  - The completed eligibility staff assessment worksheet.
  - All the required documentation.
- 

**Notice of Ineligibility**

The Notice of Ineligibility (Attachment M) along with the Notice of Rights (Attachment N) is the correspondence required by Rule.

1. The Notice of Ineligibility is reviewed with the applicant, preferably during a face-to-face interview and a copy provided to the applicant. The Notice of Ineligibility may be mailed (certified only) with the Notice of Rights, if a face-to-face interview is not possible. All efforts are made to assist the applicant with understanding the reason for the decision:
    - The applicant is advised to contact the eligibility provider for a re-determination if circumstances change.
    - Referral information (name, address and phone numbers) is provided to the applicant for possible assistance from other programs.
    - Applicants are advised of their Right to a Fair Hearing in the event of a Notice of Ineligibility on Part 6 of their signed application.
  2. If the individual is not satisfied with the explanation for ineligibility, the supervisor should assist. The Notice of Ineligibility requires the applicant's signature. If the applicant refuses, document 'refuses to sign on the signature line of the Notice of Ineligibility.
  3. The applicant can choose to pursue the instructions provided in the Notice of Rights; however, the eligibility office may not assist the individual with the appeal process, other than possible referrals to legal aide or other legal counsel.
  4. If the applicant chooses to appeal the decision, the eligibility provider will be contacted by the local or department's legal staff since the actual Right to Fair Hearings information is submitted to the Agency Clerk in Tallahassee, Florida. Copies of the application, eligibility staff assessment worksheet and other documentation may be required. No further action is required by eligibility providers unless instructed by legal counsel.
-

**Exception vs. Appeal**

Exceptions and appeals are not considered routine activity for every applicant who does not meet the eligibility requirements. There are significant differences between the “request for an exception” and the “request to appeal” a decision.

- The request for exception is initiated by eligibility provider on behalf of an applicant, and is an internal procedure authorized by the Eligibility Rule, Chapter 64D-4. FAC.
  - An appeal as explained in the Notice of Rights is initiated by the applicant, and is conducted in accordance with section 120.569, Florida Statutes. Staff must not assist clients in this process, but provide information necessary to proceed.
- 

**Hearing Procedures**

An administrative hearing may be conducted, when an applicant requests to appeal the determination of eligibility.

- Requests are sent to and reviewed by the Agency Clerk in Tallahassee, Florida.
  - The Agency Clerk may request more information about the case before deciding to grant or deny the request. A Hearing Officer in Tallahassee will be assigned the case and the local Department of Health attorney will represent the program.
  - The local legal counsel will work closely with the program or eligibility provider for more information and clarification of the case as the appeal process progresses.
- 

**Closing the File**

All active eligibility files must remain open until such a time circumstances change, such as the client: (this is not an all inclusive list)

- Moves out of state or to another area.
- Is deceased.
- Has been incarcerated.
- No longer needs services.

For applicants/clients determined ineligible, the file is closed when a final determination of ineligibility is completed and the referral and documentation material are assembled.

All closed files must follow the record retention policy located in Section 2.

---

