

March 2015

Montana HIV Treatment Assistance Program

The Montana STD/HIV/HepC Prevention Section administers several programs which increase access to HIV medical care.

- The AIDS Drug Assistance Program (also known as ADAP) with funding provided by the Ryan White Part B CARE Act which is administered through the federal Health Resources and Services Administration. This program provides HIV anti-retroviral drugs, medications to prevent opportunistic infection, some mental health medications, and certain drugs to treat HIV-related disease for individuals who are uninsured or under-insured and who are unable to pay for such treatment.
- Both state and Ryan White funds are available for health insurance premium assistance and Medicaid Cash Option payments, if deemed to be cost-effective.
- Both state and Ryan White funds are available for medication co-pay assistance for all types of insurance, including Medicare Part D.

To be eligible for assistance, an individual must meet the following criteria and furnish the following information to the Montana HIV Treatment Program:

- Have a permanent Montana address
- Have written documentation of income less than 431% of the federal poverty level (adjusted gross taxable income)
- Be ineligible for any other assistance programs that would cover such costs.
- ADAP clients are required to re-verify income every six months or as requested by the program. Copies of MarketPlace insurance eligibility letters are required as appropriate

Applicant must submit a completed HIV Treatment Program application, a recent tax return document or other income verification, and a completed medical verification form and which has been signed by an HIV case manager certifying that the client is HIV positive, and receiving care.

Insurance plans/premiums and Cash Option payments will be evaluated for cost-effectiveness before premium payment assistance is authorized.

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The information above is intended to provide a brief description of the program and the eligibility criteria. It is not intended to answer all questions concerning the services offered by the HIV Treatment Program. For specific questions, or an electronic application form, please call the Montana HIV Treatment Program at (406) 444-4744, or e-mail [jnielsen@mt.gov](mailto:jnielsen@mt.gov)

Mail or fax completed applications to:  
Rob Elkins, DPHHS  
P.O Box 202951  
Cogswell Bldg C-211  
Helena, MT 59620-2951  
Fax: 406-444-6842

March 2015

**Montana Department of Public Health and Human Services  
HIV Treatment Program    Application for Assistance**

|                                                                                                                              |                                                                                                   |
|------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| Mail to: Judy Nielsen, DPHHS<br>P.O. Box 202951<br>COGSWELL BLG C211<br>HELENA, MT 59620-2951<br><br>Or Fax to: 406-444-6842 | (This section for office use)<br>Date Received:<br>Date Approved:<br>Conditional:<br>Date Denied: |
|------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|

|                   |                |     |            |
|-------------------|----------------|-----|------------|
| NAME of applicant | Race/ethnicity | SEX | BIRTH DATE |
|-------------------|----------------|-----|------------|

|         |      |          |
|---------|------|----------|
| ADDRESS | CITY | ZIP CODE |
|---------|------|----------|

|                        |                                                     |
|------------------------|-----------------------------------------------------|
| SOCIAL SECURITY NUMBER | PHONE NUMBER:<br><i>Optional</i><br>E-Mail Address: |
|------------------------|-----------------------------------------------------|

**FAMILY INFORMATION--Provide information on your spouse and dependents.**

| Name | Birth Date | Relationship |
|------|------------|--------------|
|      |            |              |
|      |            |              |
|      |            |              |
|      |            |              |

**HEALTH INSURANCE INFORMATION**

|                                               |                                           |                                                                        |
|-----------------------------------------------|-------------------------------------------|------------------------------------------------------------------------|
| MEDICAID ELIGIBLE?                            | DATE LAST APPLIED FOR MEDICAID            | Receiving SSD?      If yes, Date:<br>Receiving SSI?      If yes, Date: |
| ARE YOU ELIGIBLE FOR INDIAN HEALTH SERVICE?   | ARE YOU ELIGIBLE FOR VETERANS ASSISTANCE? |                                                                        |
| Name of INSURANCE COMPANY                     | Name of POLICY HOLDER                     |                                                                        |
| ADDRESS                                       | GROUP NUMBER/POLICY NUMBER                |                                                                        |
| THIS POLICY PAYS FOR _____ % OF PRESCRIPTIONS | Deductible Amount:                        |                                                                        |
| Cost of Premium per Month                     | Annual Maximum Out-of-Pocket Cost         |                                                                        |

Type(s) of assistance requested:

- ACA Premium Payment (Must be deemed cost-effective.)
- Private Insurance Premium Payment (Must be cost-effective.)
- Employment Health Insurance Premium Reimbursement
- Medication co-pay assistance (Must use ADAP pharmacy)
- Medicaid Cash Option Payment (Must be cost-effective)
- Full ADAP (uninsured)

**INCOME TAX INFORMATION--Provide a copy of your latest state or federal tax return form**

**INCOME INFORMATION—Also Provide information on all net incomes in your household below**

| <i>List all sources of income for yourself and your spouse</i> | <i>Person who receives income</i> | <i>Average Annual Income</i> |
|----------------------------------------------------------------|-----------------------------------|------------------------------|
|                                                                |                                   |                              |
|                                                                |                                   |                              |

Excluding (not counting) the home you live in and one vehicle, do you own property, other vehicles or liquid assets (bank or credit union accounts, CDs, cash, stocks, etc.) with a combined equity value (the value of the asset minus any money you owe on the asset) of:

- \$2,000.00 for a single individual       yes       no
- \$3,000.00 for a married individual       yes       no

Have you been declared blind or disabled by the federal Social Security Administration?     yes     no

*You may be required to provide the Montana ADAP program with written evidence of Medicaid denial.*

**CERTIFICATION**

I am applying for the above specified HIV treatment services provided through the Montana Department of Public Health and Human Services. I declare that I have examined the information given on this application and that it is true, correct and complete. I understand that if I have willfully misrepresented any information on this application, benefits may be terminated.

I understand that I must participate in HIV treatment and care to be eligible for services.

Applicant signature \_\_\_\_\_ Date \_\_\_\_\_

**RELEASE OF INFORMATION**

I, (print) \_\_\_\_\_, authorize state program administrative staff to share information with public or private insurance programs for which I may be eligible, my health care providers and case managers, and pharmacies designated to fill my prescriptions. This authorization is valid while I am a recipient of state-administered benefits.

**If I included an e-mail address, I authorize program, medical and pharmacy staff to communicate with me using e-mail. I understand that e-mail systems are not confidential.**

Applicant signature \_\_\_\_\_ Date \_\_\_\_\_

March 2015

|                                                                |
|----------------------------------------------------------------|
| <b>MEDICAL VERIFICATION for Montana HIV Treatment Programs</b> |
|----------------------------------------------------------------|

|                            |
|----------------------------|
| <b>PATIENT INFORMATION</b> |
|----------------------------|

|       |             |
|-------|-------------|
| Name: | Birth date: |
|-------|-------------|

|                            |
|----------------------------|
| <b>MEDICAL INFORMATION</b> |
|----------------------------|

|                                        |                                                                  |                                        |
|----------------------------------------|------------------------------------------------------------------|----------------------------------------|
| HIV Status:                            | HIV Positive Stage: 1 2                                          | Date of 1 <sup>st</sup> positive test: |
|                                        | AIDS Stage: 3 4                                                  | AIDS Date:                             |
| Hepatitis C Status:                    | Tested Negative _____ Date tested:                               |                                        |
|                                        | Chronic Hepatitis C _____ Date of 1 <sup>st</sup> positive test: |                                        |
| <b>Date</b> of most recent CD4:        | CD4 Count:                                                       | CD4 %:                                 |
| <b>Date</b> of most recent Viral Load: | Copies:                                                          | Test Type: _____ PCR<br>_____ bDNA     |

|                                     |
|-------------------------------------|
| <b>Medical Provider INFORMATION</b> |
|-------------------------------------|

|               |        |
|---------------|--------|
| PRINTED Name: | Phone: |
| Facility:     | City:  |

I certify that the above patient is:

\_\_\_ HIV infected

\_\_\_ Currently in care

Case Manager/Medical Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

NOTE: HIV/AIDS cases are reportable by Montana law. Please contact the local county health officer or the Montana HIV Surveillance Program at 406-444-4735 for more information or a reporting form.

Please mail or fax this form to:

**Rob Elkins, DPHHS**  
**P.O. Box 202951**  
**Cogswell Bldg C-211**  
**Helena, MT 59620-2951**

**Fax: 406-444-6842**  
**Phone: 406-444-4744**