

**FOR AICP OFFICE USE ONLY:**  
**AICP #:**

**QUALIFICATION SCREENING DECISION PATH FOR  
THE AIDS INSURANCE CONTINUATION PROGRAM**

Below is a Decision Path which should be used to determine whether an applicant meets the criteria for enrollment into the AIDS INSURANCE CONTINUATION PROGRAM (AICP). If the applicant can answer "YES" to all of the following statements, he/she may apply for participation in the AICP.

***CURRENTLY MEETS HIV/AIDS PATIENT CARE PROGRAM ELIGIBILITY CRITERIA:***

IF YES, CONTINUE

IF NO, DOES NOT MEET CRITERIA

***IS HIV+ (ASYMPTOMATIC OR SYMPTOMATIC) OR A DIAGNOSIS OF AIDS***

IF YES, CONTINUE

IF NO, DOES NOT MEET CRITERIA

***CURRENTLY HAS HEALTH INSURANCE UNDER A GROUP, INDIVIDUAL, OR COBRA POLICY***

IF YES, CONTINUE

IF NO, DOES NOT MEET CRITERIA

***IS WILLING TO SIGN ALL FORMS***

IF YES, CONTINUE

IF NO, DOES NOT MEET CRITERIA

The Community Based Organization Representative should check the appropriate line below and provide the information requested.

\_\_\_\_\_ This person meets the criteria to apply for participation in the AIDS INSURANCE CONTINUATION PROGRAM and has received an application packet.

\_\_\_\_\_ This person does not meet the criteria to apply for the AIDS INSURANCE CONTINUATION PROGRAM.

Agency Client ID # or Name: \_\_\_\_\_ Date of Screening: \_\_\_\_\_

The first premium paid by the AICP (was/will be) paid on \_\_\_\_\_ in the amount of \$ \_\_\_\_\_  
and will provide coverage from \_\_\_\_\_ through \_\_\_\_\_.

**EFFECTIVE MAY 2009**



FOR AICP OFFICE USE ONLY: AICP #:
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**AIDS INSURANCE CONTINUATION PROGRAM APPLICANT DATA COLLECTION FORM**

**Assurance of Confidentiality**

All information that you provide on this data collection form or for the completion of the enrollment criteria will be kept strictly confidential to the fullest extent allowable by law. The data collected will be in aggregate form only and the identity of any applicants will not be revealed under any circumstances. **THE FOLLOWING INFORMATION IS REQUIRED FROM ALL POTENTIAL PARTICIPANTS. ALL SPACES MUST BE FILLED IN. IF THE QUESTION DOES NOT APPLY, STATE "N/A" IN THE SPACE PROVIDED. INCOMPLETE APPLICATIONS WILL BE RETURNED. PLEASE PRINT OR TYPE:**

**DEMOGRAPHIC INFORMATION**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Gender:  Male  Female  Transgender

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ URN (optional): \_\_\_\_\_

Race:  White  Black  Native American  Asian  Pacific Islander  Multiracial

Ethnicity:  Hispanic  Non-Hispanic

**CONTACT INFORMATION:**

Secure Home Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_  
 Number and Street

\_\_\_\_\_ Zip: \_\_\_\_\_  
 City and State

Secure Mail Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_  
 (if different) Number and Street

\_\_\_\_\_ Zip: \_\_\_\_\_  
 City and State

Secure Phone Number: \_\_\_\_\_

**HEALTH INSURANCE INFORMATION: A COPY OF BOTH SIDES OF YOUR INSURANCE CARD, AND THE PREMIUM PAYMENT COUPON MUST BE ATTACHED.**

Insurance Company Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Insurance Type:  COBRA  Group  Individual  Private Medication Supplement Policy

Policy type?  HMO  PPO  POS  Traditional (Indemnity)



FOR AICP OFFICE USE ONLY: AICP #:

If COBRA: when will your coverage end? \_\_\_\_\_

If Group: Group name \_\_\_\_\_ Policy number \_\_\_\_\_

For COBRA & Group Policies: Federal Employee Identification Number (FEIN) \_\_\_\_\_

Is this a Family policy?  Yes  No

Does your policy cover your prescriptions? (If yes include proof with application)  Yes  No

If no, how do you get your medications?  ADAP  Medicaid  Compassionate Use  VA  Other

Premium amount: \$ \_\_\_\_\_

Premium is paid:  Weekly  2 Weeks  Monthly  2 Months  3 Months  6 Months

Do you have Medicaid?  Yes  No

**FEDERAL POVERTY LEVEL:**

- Total monthly income:  0 - 100% FPL
- 150% FPL  200% FPL  250% FPL
- 300% FPL  350% FPL  400% FPL

I declare that all statements made on this data collection form are true and complete to the best of my knowledge and I REALIZE THAT WILLFUL FALSIFICATION OF THIS INFORMATION BY ME MAY SUBJECT ME TO IMMEDIATE DISQUALIFICATION FOR PARTICIPATION IN THE AICP. I ALSO UNDERSTAND THAT IF I QUALIFY FOR PARTICIPATION, THE AICP MAY STOP PAYING MY INSURANCE PREMIUMS IF FUNDING FOR THIS PROJECT RUNS OUT, IS DISCONTINUED OR MY INSURANCE POLICY EXPIRES. Furthermore, I understand that it is MY RESPONSIBILITY TO SUPPLY THE COMMUNITY BASED ORGANIZATION WITH THE PREMIUM NOTICES I receive from my insurance company, thus ensuring that they are aware of my premium due date. I release this complete applicant data form to the Health Council of South Florida, Inc. for enrollment determination and data collection.

Applicant's Signature \_\_\_\_\_

\_\_\_\_\_ Date

## AIDS INSURANCE CONTINUATION PROGRAM--PHYSICIAN'S STATEMENT OF DIAGNOSIS

Patient Name: \_\_\_\_\_ SS# \_\_\_\_\_

**STEP 1. Check one of the following:**

- This patient tested positive for HIV on \_\_\_\_\_ OR  This patient has NOT tested positive for HIV  
 (Date)
- This patient was diagnosed with AIDS on \_\_\_\_\_ OR  This patient has NOT been diagnosed with AIDS  
 (Date)

**STEP 2. Please circle one of the following CDC Staging Classifications using the chart below AND the symptom charts in STEP 4 as guides:**

		A1	A2	A3	B1	B2	B3	C1	C2	C3
		Clinical Categories								
CD4 + T-cell Categories	CD4 + Percentage	(A) Asymptomatic Acute (primary) HIV or PGL			(B) Symptomatic Not (A) or (C) conditions			(C) AIDS-Indicator Conditions		
(1) > 500/uL	>29%	A1			B1			C1		
(2) 200-499/uL	14-28%	A2			B2			C2		
(3) <200/uL AIDS indicator T-cell count	<14%	A3*			B3			C3		

\* A3 is an AIDS indicator, regardless of the presence of symptoms; i.e. the client is eligible for AICP

**STEP 3. LABORATORY VALUES AT TIME OF AIDS DIAGNOSIS OR, IF HIV + ONLY, MOST RECENT RESULTS:**

CD4 (Absolute/Percent) \_\_\_\_\_ / \_\_\_\_\_ % as of \_\_\_\_\_ (Date)

Viral Load \_\_\_\_\_ copies per ML as of \_\_\_\_\_ (Date)

**STEP 4. PLEASE CHECK THE FOLLOWING SYMPTOMS/CONDITIONS THE PATIENT HAS HAD AT ANY TIME SINCE TESTING HIV POSITIVE:**

**A. Conditions include:**

- \_\_\_\_\_ PGL Persistent Generalized Lymphadenopathy      \_\_\_\_\_ Acute or primary HIV infection with current or previous history of illness
- \_\_\_\_\_ Asymptomatic HIV infection

**B. Category B consists of symptomatic conditions in an HIV infected adolescent or adult that are not included among conditions listed in clinical Category C and that meet at least one of the following criteria: (a) the conditions are attributed to HIV infection or are indicative of a defect in cell mediated immunity; or (b) the conditions are considered by physicians to have a clinical course or to require management that is complicated by HIV infection. Examples of conditions in clinical Category B include, but are not limited to:**

- |  |   |
|--|---|
| _____ Bacillary angiomatosis   | _____ Herpes zoster (shingles), involving at least two distinct episodes or more than one dermatoma |
| _____ Candidiasis, oropharyngeal (thrush)  | _____ Idiopathic thrombocytopenic purpura   |
| _____ Candidiasis, vulvovaginal, frequent, or poorly responsive to therapy         | _____ Listeriosis   |
| _____ Cervical dysplasia (moderate or severe)/cervical carcinoma in situ           | _____ Pelvic inflammatory disease, particularly if complicated by tubo-ovarian abscess              |
| _____ Constitutional symptoms, such as fever (38.5 C) or diarrhea lasting >1 month | _____ Peripheral neuropathy   |
| _____ Hairy leukoplakia, oral  | _____ Other (please list)* _____  |

\*(Any condition related to side effects/toxicity of antiretroviral therapy, i.e. hyperlipidemia, lipodystrophy, lipohypertrophy)

## AIDS INSURANCE CONTINUATION PROGRAM--PHYSICIAN'S STATEMENT OF DIAGNOSIS

<b>C. Conditions Include:</b>
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- |  |  |
|--|--|
| <input type="checkbox"/> Candidiasis of bronchi, trachea, or lungs<br><input type="checkbox"/> Candidiasis, esophageal<br><input type="checkbox"/> Cervical cancer, invasive<br><input type="checkbox"/> Coccidioidomycosis, disseminated or extrapulmonary<br><input type="checkbox"/> Cryptococcosis, extrapulmonary<br><input type="checkbox"/> Cryptosporidiosis, chronic intestinal (>1 month's duration)<br><input type="checkbox"/> Cytomegalovirus disease (other than liver, spleen, or nodes)<br><input type="checkbox"/> Cytomegalovirus retinitis (with loss of vision)<br><input type="checkbox"/> Encephalopathy, HIV related<br><input type="checkbox"/> Herpes simplex: chronic ulcer(s) (>1 month's duration); or bronchitis, pneumonitis, or esophagitis<br><input type="checkbox"/> Histoplasmosis, disseminated or extrapulmonary<br><input type="checkbox"/> Isosporiasis, chronic intestinal (>1 month's duration)<br><input type="checkbox"/> Kaposi's sarcoma<br><input type="checkbox"/> Lymphoma, Burkitt's (or equivalent term) | <input type="checkbox"/> Lymphoma, immunoblastic (or equivalent term)<br><input type="checkbox"/> Lymphoma, primary of brain<br><input type="checkbox"/> Mycobacterium avium complex or M. Kansasii, disseminated or extrapulmonary<br><input type="checkbox"/> Mycobacterium tuberculosis, any site (pulmonary or extrapulmonary)<br><input type="checkbox"/> Mycobacterium, other species or unidentified species, disseminated or extrapulmonary<br><input type="checkbox"/> Pneumocystis carinii pneumonia<br><input type="checkbox"/> Pneumonia, recurrent<br><input type="checkbox"/> Progressive multifocal leukoencephalopathy<br><input type="checkbox"/> Salmonella septicemia, recurrent<br><input type="checkbox"/> Toxoplasmosis of brain<br><input type="checkbox"/> Wasting Syndrome due to HIV<br><input type="checkbox"/> Other (please list below) |
|--|--|

**Patient's Release:** *I hereby authorize you to release this completed physician's statement of diagnosis to CBO and to the Health Council of South Florida for use in the AIDS Insurance Continuation Program.*

Client Signature: \_\_\_\_\_

Physician/ARNP Signature: \_\_\_\_\_

Physician/ARNP Name: \_\_\_\_\_

Physician/ARNP License #: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone: \_\_\_\_\_

Case Manager Name: \_\_\_\_\_

(Please Print Clearly)

Case Manager Phone: \_\_\_\_\_



## AUTHORIZATION FOR RELEASE OF HIV/AIDS INFORMATION

Florida law requires that information contained in medical records be held in strict confidence and not be released without your written authorization. The authorization contained on this page will remain in effect until you request in writing that your authorization be withdrawn, which you may do at any time. You have a right to receive a copy of this authorization upon your request. Please note, in applying for the AICP you, previously agreed to sign all applicable forms as a requirement of your continued enrollment in the program.

I, \_\_\_\_\_ (printed name of client), do hereby authorize the Health Council of South Florida, Inc. and the Florida Department of Health to release to the Agency for Health Care Administration, as administrator of the Florida Medicaid program, my social security number, and any financial and demographic information contained in my application for the insurance continuation program that may be necessary to determine my eligibility for services and/or funding through Medicaid.

\_\_\_\_\_  
Signature of Client or Legal Representative

\_\_\_\_\_  
Client Social Security Number

\_\_\_\_\_  
Legal Representatives Relationship to Client

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date



# CLIENT CONSENT TO FAX CONFIDENTIAL INFORMATION

Florida law requires that information contained in medical records be held in strict confidence and not be released without your written authorization. You must give specific written authorization to release certain types of sensitive medical information. The Florida Department of Health may fax confidential medical information to a provider or receive faxed information that was requested from a provider with your permission. Faxing such information is voluntary. You will not be denied services based on a refusal to allow your confidential information to be faxed.

Steps will be taken to make sure your information arrives safely, but faxes can be misdirected.

I, \_\_\_\_\_, do hereby authorize: \_\_\_\_\_  
(name of client/legal representative) (Agency or Individual in possession of the record)

Address (street, city, state) of agency/individual with record

to fax the following information: (initial by any or all that apply)

- a. STD records
- b. TB records
- c. HIV/AIDS records
- d. Drug/alcohol treatment records
- e. Psychiatric/psychological information/records
- f. Adult and child abuse information
- g. Other (specify) \_\_\_\_\_

This information will be faxed to:

Provider Name (fax recipient)	<b>Health Council of South Florida, Inc.</b>
Contact Person	<b>Francia Alcalá</b>
Provider Phone Number	<b>305-592-1452</b>
Provider Fax Number	<b>305-592-0981</b>

Signature of Client or Legal Representative \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_

Legal Representative's Relationship to the Client

<b>USE THIS SPACE ONLY IF CLIENT WITHDRAWS CONSENT</b>	
_____	_____
<b>Date Consent Revoked</b>	<b>Signature of Client or Legal Representative</b>
_____	_____
<b>Witness</b>	<b>Legal Representative's Relationship to Client</b>

Client Name \_\_\_\_\_  
 ID Number \_\_\_\_\_  
 Date of Birth \_\_\_\_\_

Instructions are on the reverse

## RELEASE OF MEDICAL INFORMATION

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

### Instructions for Completion of Consent to Fax

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

**ASSIGNMENT OF PRO RATA REFUND**

I, the undersigned, hereby assign to the State of Florida, through its agent, \_\_\_\_\_ (CBO), any interest that I might have in any unearned premium which may be due me under this insurance policy. I hereby instruct the insurance company to promptly deliver the said unearned premium to:

CBO \_\_\_\_\_

Address \_\_\_\_\_

City, State Zip \_\_\_\_\_

Please notify the aforementioned agency immediately upon the determination that such funds are due. I acknowledge and give my consent for the distribution of this document to my insurance carrier(s), insurance administrator(s), and employer(s) for their records. A facsimile of this document is as effective as the original.

\_\_\_\_\_  
Insured's Signature                      Date

\_\_\_\_\_  
Witness' Signature                      Date

\_\_\_\_\_  
Insured's Printed Name                      Date

\_\_\_\_\_  
Witness' Printed Name                      Date

**ACKNOWLEDGMENT OF CLAIM AGAINST ESTATE**

I hereby acknowledge a claim against my estate for any unearned premium(s) which may have been erroneously distributed to me or my estate. I hereby agree to promptly return to the State of Florida Department of Health, with \_\_\_\_\_ (CBO) acting as its agent, any unearned premium refund that I might receive and that, in the event that any action for the collection of the same should be brought by the CBO against me or my estate, I agree to be liable for attorney's fees and court costs in addition to said refunded premium.

\_\_\_\_\_  
Insured's Signature                      Date

\_\_\_\_\_  
Witness' Signature                      Date

\_\_\_\_\_  
Insured's Printed Name                      Date

\_\_\_\_\_  
Witness' Printed Name                      Date

## Statement of Client Rights & Responsibilities

I understand that as a participant in the **AIDS Insurance Continuation Program (AICP)**, I have both rights and responsibilities as listed below, and failure to comply with any one of the responsibilities can result in my termination from the program:

**I have the right** to freedom of choice - I have the right to choose to receive AICP case management and/or fiscal agent services from any organization within the State of Florida that has been duly authorized and trained by the AICP to perform such duties.

**I have the right** to submit grievances directly to the AICP Director for instances of denied enrollment, ineffective AICP case management, and/or ineffective fiscal payment services, etc.

**I acknowledge** that if I qualify for participation, the AICP may not be able to pay my premiums continuously if funding for the AICP is severely limited, or discontinued.

**I acknowledge** that it is my responsibility to keep my insurance active prior to the approval of my AICP application and that my enrollment in the AICP is dependant upon my possession of an active and valid health insurance policy, and that the payment of any health insurance premium back payments is my responsibility unless otherwise authorized.

**I agree** to continue paying my health insurance premiums until such time as my AICP case manager notifies me by phone, mail or in person that the AICP has accepted my application for official program enrollment, and indicates the date upon which AICP will begin paying my premiums.

**I agree** that if I am placed on the AICP delay-in-service waiting list, pending official program enrollment, the payment of all health insurance premiums will continue to be my sole responsibility, until such time that I am informed by my case manager that official program enrollment has occurred.

**I will** provide an insurance premium notice to my designated AICP case manager each month in order that my premium may be paid on time. I understand that if I do not provide this notice, even one time, the program will not pay my insurance premium, and my insurance company may cancel my policy.

**I will** make contact with my designated AICP case manager a minimum of once every 60 days, of which one contact every six-months must be in person. If I do not make this 60-day contact, even if my premium has already been paid for that period, my designated AICP case manager will assume that I am no longer in the program, will seek a refund for premiums already paid, and will not pay any future premiums.

**I will** immediately notify the community-based organization of changes of income, address, phone number, insurance policy information, premium increases or decreases.

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**I will** sign all forms and paperwork required by the program.

**I will** complete an annual AICP client survey once a year. The results of this survey will be tabulated, in aggregate form to protect my confidentiality, and will be included in an analysis of the effectiveness of the program.

**I understand** my rights and responsibilities listed above as conditions of participation in the insurance program. I will comply with all of these requirements.

**I also acknowledge** the following:

Acceptance into the AICP is not automatic upon application. The application is a process; involving those steps described in the information packet I have been given.

The Health Council of South Florida, Inc. reviews all documents forwarded to them by my case manager and either approves or denies my AICP application.

Acceptance into the AICP is based on my having met all enrollment criteria, and on the Program's ability to accept new clients at the time of enrollment.

Client Signature:	Case Manager Signature:
Print Name:	Print Name:
Date:	Date:

## **Memorandum of Understanding**

### **Confidentiality of Client Information**

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

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

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

I understand and agree to abide by these confidentiality provisions.

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**Employee Signature**

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**Date**

**AIDS INSURANCE CONTINUATION PROGRAM  
--FINAL CHECKLIST FOR PROGRAM QUALIFICATION--**

The following checklist should be used by the community-based organization representative to monitor the applicant's file for completeness, ensuring that all required documentation is collected for enrollment determination.

<b>CLIENT INFORMATION</b>	
<input type="checkbox"/>	Has completed and signed the Applicant Data Collection Form (copy sent to HCSF)
<b>DIAGNOSIS</b>	
<input type="checkbox"/>	Has a diagnosis of AIDS or is HIV Positive (Asymptomatic or Symptomatic)
<input type="checkbox"/>	Has submitted the completed <i>Physician's Statement of Diagnosis</i> (copy sent to HCSF)
<b>PROOF OF INSURANCE AND PHARMACY BENEFITS</b>	
<input type="checkbox"/>	Has health insurance coverage under a group, individual, or COBRA policy.
<input type="checkbox"/>	Has submitted a copy of <b>both</b> sides of insurance card or policy benefit statement. (copy sent to HCSF)
<input type="checkbox"/>	Has submitted documentation of HIV/AIDS medication coverage. (copy sent to HCSF)
<input type="checkbox"/>	Has submitted a copy of the premium payment coupon or letter.
<b>PROOF OF HIV/AIDS PATIENT CARE PROGRAM ELIGIBILITY: (verification sent to HCSF)</b>	
<input type="checkbox"/>	Copy of HIV/AIDS Patient Care Program <i>Notice of Eligibility</i> sent to HCSF
<b>OTHER</b>	
<input type="checkbox"/>	Has signed the Release of Information forms (copy sent to HCSF)
<input type="checkbox"/>	Has completed and signed Assignment of Pro Rata Refund Form and Acknowledgment of Claim Against Estate Form (copy sent to HCSF)
<input type="checkbox"/>	Has completed and signed Client Statement of Client Rights & Responsibilities (copy sent to HCSF)

**APPLICANT'S NAME** (please print): \_\_\_\_\_

This application is now being processed through \_\_\_\_\_  
*CBO Name*

I have reviewed this applicant's entire application which includes all information and documentation needed for enrollment into the AIDS Insurance Continuation Program (AICP). I understand that when all of the above items are checked off, this applicant meets the criteria for participation in the AICP. I will contact the program manager for authorization to enroll this individual or have received prior authorization to do so.

\_\_\_\_\_  
 CBO Representative's Name

\_\_\_\_\_  
 Date