MISSISSIPPI STATE DEPARTMENT OF HEALTH

Thank you for your interest in Ryan White Part B services. Enclosed is the Ryan White Part B Eligibility Application Packet, which contains the forms and instructions needed to determine eligibility and to begin or continue services. Please review each item carefully, complete all required forms, and submit the packet with the requested documentation to avoid delays in processing.

What's Included in This Packet

Required Forms

- Frequently Asked Questions (FAQ)
- Ryan White Part B Eligibility Application
- Informed Participation Agreement (IPA)
- HIPAA Acknowledgement/Authorization (as applicable)
- Clinic Information Form
- Mississippi Insurance Assistance Program (IAP) Forms
- Statement of No Change Form (for eligible renewals, when applicable)
- Grievance Procedures (for your records)

Attestation Forms (Complete only if they apply to you)

- Incarcerated Persons Facility Attestation (when applicable)
- No Income Attestation
- No Insurance Attestation
- Unhoused/Homeless Attestation
- Special Income Circumstances Attestation (as applicable)
- Other supporting attestations as needed to verify eligibility and program requirements

Documentation Required to Process Your Application

To determine eligibility, you must include copies of the following (as applicable):

- **Proof of Residency**
- **Proof of Income** (or applicable attestation if no income or special circumstances)
- **Proof of Insurance Status** (or applicable attestation if uninsured)
- **Proof of HIV Status** (as required/accepted by program policy)

Please ensure that all forms are signed and dated. If any portion of the packet is incomplete or documentation is missing, processing may be delayed and additional information may be requested.

MISSISSIPPI STATE DEPARTMENT OF HEALTH

If you have questions or need assistance completing the packet, please contact your case manager or clinic, or reach the ADAP/Ryan White Part B office at **601-362-4879** or **RyanWhite.PartB@msdh.ms.gov or ADAP.Services@msdh.ms.gov.**

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Respectfully,

Patricia Webb

ADAP Director

Ryan White Part B

Mississippi State Department of Health

Frequently Asked Questions (FAQ) for Enrollment in the

Mississippi Ryan White Part B and ADAP Program

1. **What is the Ryan White Part B Program?**

   The Ryan White Part B program is a federal initiative that provides funding for HIV/AIDS care and treatment services for individuals who are uninsured or underinsured in the state of Mississippi.

2. **What is the AIDS Drug Assistance Program (ADAP)?**

   ADAP is a component of the Ryan White program that provides medication and treatment assistance to uninsured or underinsured individuals living with HIV/AIDS. The program helps cover the costs of medication for eligible individuals.

3. **Who is eligible to enroll in the Ryan White Part B and ADAP programs?**

   To be eligible, you must:

   - ❖ Have a positive HIV/AIDS diagnosis
   - ❖ Reside in the state of Mississippi
   - ❖ Must have a household income below the Federal Poverty Level for Mississippi
   - ❖ Must obtain the services available through Medicaid, Medicare, SCHIP, Federal Exchange Marketplace plans, or other payor(s) if covered.

4. **How do I apply for the Ryan White Part B and ADAP programs?**

   To apply, you may contact your local service provider organizations or contact Mississippi State Department of Health (MSDH) at **601-362-4879** or by email at RyanWhite.PartB@msdh.ms.gov to be connected to a MSDH

Case Manager or Social Worker for assistance with linkage to care.

5. **What documents are needed to apply?**

   Proof of Income: most recent W-2, 2 recent paycheck stubs, Social Security statement, unemployment check/letter, workman's compensation letter, or if self-employed completed tax return. Please provide proof of income for all amounts listed. All documents provided, except for Social Security statement, **must be LESS than 6 months old.** An individual who does not have the required Proof of Income documentation, can complete an **Income Self-Attestation Form** including the sources of income and gross amounts.

   Proof of Insurance or Medicare (if applicable): If you have insurance available, you MUST submit a copy, FRONT AND BACK, of your insurance card. An individual who does not have the required Proof of Insurance documentation can include this information on the insurance portion of the Eligibility Application. If uninsured, you must vigorously pursue insurance benefits or documents with your initial application and your refusal to participate in an insurance benefits program.

   Proof of Positive HIV Status: Provide a complete name-linked verification of HIV positive status. The following items may be used to verify HIV status: 2 reactive rapid HIV tests conducted on the same day, a positive signed and dated Clinical Information Form (CIF), a testing counselor who has been certified by the Centers for Disease Control and Prevention (CDC) training "Implementing HIV Testing in Non-clinical Settings" may sign and verify HIV status

utilizing the CIF, or a discharge summary or other hospital record that verifies HIV positive status.

Proof of Residency: You MUST submit one of the following: current copy of signed lease, most recent utility bill, valid driver's license or official state ID that includes current address, other official mail, or statement from a person providing room and board. Proof of current physical address must match the address listed on the application. **P.O. boxes will not be accepted**. *An individual who does not have the required Proof of Residency documentation, can complete a Residency Self-Attestation Form including the city, state, and zip code.*

6. **Will I have to pay for services once I am enrolled?**

   Services under the Ryan White Part B and ADAP programs are provided at little or no cost to you. However, some co-pays may apply depending on your insurance plan and specific service.

7. **Can I enroll if I already have health insurance?**

   The Ryan White Part B | ADAP program is a payor of last resort; however, individuals with health insurance may still be eligible for Ryan White Part B and ADAP programs if their insurance does not cover all their HIV | AIDS-related needs.

8. **How often do I need to renew my enrollment once approved?**

   Recertification is annually (once per year) during the anniversary month of your enrollment. A 30-day grace period is allowed.

However, it is your responsibility to notify your case manager of changes to your income, residency, or health status to avoid interruptions to services.

9. What about labs?

Labs are required to be updated every six months. Your case manager or care provider can assist with scheduling for follow-up care appointments.

10. How are medications provided?

As a recipient of Ryan White Part B | ADAP services, three options are offered for dispensing medications:

- Medications may be picked up at the local county Health Department
- Medications may be shipped to a physical address provided by the client (Post Office Boxes are not accepted)
  - After receipt of the first shipment, you must call the MSDH Pharmacy at least seven (7) days **BEFORE** refills are due at **1-800-264-6635**
- Medications may be delivered to an approved Primary Care Provider

11. What happens if I do not pick up my medications or do not call for an update?

If you miss a scheduled medication pickup, you will not lose your ADAP eligibility. Our team may reach out to check in and help address any barriers such as transportation, illness, or pharmacy scheduling issues. Our goal is to support your continued access to care

12. How will I know when it is time to recertify?

The Eligibility staff at MSDH will contact the case managers by email within 45 days of the recertification month. Your case managers will contact you directly within 30 days of your appointment.

13. Will I receive anything in the mail about recertification?

It is not the practice of MSDH to send notifications for recertifications in the mail; however, your case managers and/or care providers may choose this as a method of delivery.

14. What happens if I do not recertify?

If recertification is not completed during the dedicated time, services for Ryan White Part B and ADAP may be discontinued. You may re-enroll; however, this will start the process from the beginning.

15. Can I continue to receive services if I move out of state?

While Ryan White and ADAP services are provided across the United States; the eligibility for this program is only credible as a Mississippi resident. It may be possible for our case management team to assist in your transition, if applicable.

***Anyone wishing to receive ADAP, Insurance Continuation, or Core Medical/Support Services funded through Ryan White Part B must complete this application and be determined to be eligible by the Mississippi State Department of Health (MSDH), Ryan White Part B | Care and Services prior to receiving the services. The only exception is Case Management/Care Coordination for the purpose of completing the application for eligibility certification or recertification for services.**

Application Check List

Before submitting your application, **BE SURE YOU INCLUDED**:

☐ **Proof of Residency**
You MUST submit one of the following: current copy of signed lease, most recent utility bill, valid driver's license or official state ID that includes current address, other official mail, or statement from a person providing room and board. Proof of current physical address must match the address listed on the application. **P.O. boxes will not be accepted**. An individual who does not have the required Proof of Residency documentation, can complete a **Residency Self-Attestation Form** including the city, state, and zip code.

☐ **Proof of Income**
You MUST submit one of the following: most recent W-2, 2 recent paycheck stubs, Social Security statement, unemployment check/letter, workman's compensation letter, or if self-employed completed tax return. Please provide proof of income for all amounts listed. All documents provided, except for Social Security statement, **must be LESS than 6 months old.** An individual who does not have the required Proof of Income documentation, can complete an **Income Self-Attestation Form** including the sources of income and gross amounts.

☐ **Proof of Insurance or Medicare (If applicable)**
If you have insurance available, you MUST submit a copy, FRONT AND BACK, of your insurance card. An individual who does not have the required Proof of Insurance documentation, can include this information on the insurance portion of the Eligibility Application. If uninsured, you must vigorously pursue insurance benefits or document with your initial application your refusal to participate in an insurance benefits program.

☐ **Proof of Positive HIV Status**
Provide a complete name-linked verification of HIV positive status. The following items may be used to verify HIV status: 2 reactive rapid HIV tests conducted on the same day, a positive signed and dated Clinical Information Form (CIF), a testing counselor who has been certified by the Centers for Disease Control and Prevention (CDC) training "Implementing HIV Testing in Non-clinical Settings" may sign and verify HIV status utilizing the CIF, or a discharge summary or other hospital record that verifies HIV positive status.

RYAN WHITE PART B SERVICES ELIGIBILITY APPLICATION

AIDS Drug Assistance Program (ADAP)

Please make sure ALL blanks on the application form are complete and all required proof is submitted. Failure to complete the entire application may cause your approval to be delayed.

The following forms are required for the Initial Application and for the Annual Recertification:

- ☐ Completed Application
- ☐ Informed Participation Agreement (IPA) Form
- ☐ Grievance Procedures Form
- ☐ Health Insurance Portability and Accountability Act (HIPAA) Release of Information Form/Self-Attestation Form(s)
- ☐ Proof of Eligibility Requirements
- ☐ Proof of Status (Initial Application)/Clinical Information Form (Annual Recertification)

The following forms must be submitted semi-annually and/or for notification of changes: for a:

- ☐ Statement of No Change/Report of Change
- ☐ Clinic Information Form (CIF).
    - Updated lab work is required every six months and must be submitted with the statement of change/no change information.

For Report of Change, include supporting documentation.

RYAN WHITE PART B SERVICES ELIGIBILITY APPLICATION
AIDS Drug Assistance Program (ADAP)

Initial Application & Re-certification Form

I understand that I can enroll through any Ryan White HIV/AIDS Program (RWHAP) funded agency in the state or by requesting an application and mailing it to: Mississippi State Department of Health, PO Box 1700 | Jackson, MS 39216 | Attn: ADAP Director (Ryan White Office) or by emailing RyanWhite.PartB@msdh.ms.gov

1. Applicant Information:

Applicant name: _____

_____

Physical address (street address): _____

City: _____ State: _____ Zip: _____

Mailing address (street name or P.O. box): _____

City: _____ State: _____ Zip: _____

Requested mailing address (if different than above): **Drugs** ☐ **Correspondence** ☐

_____

Social Security #: _____ Date of birth: _____

Home phone: ( ) _____ County of residence: _____

Cell phone: ( ) _____ _____ Male _____ Female _____

Sex at birth: _____ _____

Race: _____ Ethnicity: _____

NOTE: We may have to call you at home with questions. Please let us know how and/or if we should leave messages regarding your HIV services if you are not available.

_____

2. Medical Provider/Social Services:

HIV medical provider name: _____

Case manager/care coordinator name: _____

3. Medical Coverage (please check all applicable):

____ I have Medicaid

____ I have temporary Medicaid Expiration date _____
(Please provide a copy of your card)

____ I have Medicare

____ I have other prescription coverage plan

____ I have private insurance

____ No insurance

Please complete the information below and send a copy (front and back) of your insurance card with this application.

4. Household/Income Information:

Total Household size: _____
Check all that apply:
☐ Client___ ☐ Family (Ages) Spouse___ Children___ Other____ ☐ Non-Family ____

Check here if you have NO income ☐
If so, please skip to Section 5 and complete a Statement of No Income.

Monthly Gross Income: $_____

Source	**Client**	**Family**	**Non-Family**
Job *(check one) Employed __ Self-employed__*	$_____	$_____	$_____
Social Security	$_____	$_____	$_____
Unemployment Benefits	$_____	$_____	$_____
Social Security Disability (SSDI)	$_____	$_____	$_____
Supplemental Security Income (SSI)	$_____	$_____	$_____
Survivorship Benefits	$_____	$_____	$_____
Child Support	$_____	$_____	$_____
Retirement/Pension/Private Disability	$_____	$_____	$_____
Veterans Administration (VA) Benefits	$_____	$_____	$_____
Worker's Compensation	$_____	$_____	$_____
Other:	$_____	$_____	$_____
TOTAL:	**$**_____	**$**_____	**$**_____

*** Do not include inheritance as income.***

5. Disclosure Statement:

The information provided in this application will be used to determine eligibility, provide services, ensure compliance with federal guidelines, and apply for future funding for ADAP and/or Ryan White Part B care and support services. Some information will be disclosed to the Mississippi HIV/AIDS Surveillance Program as required for statistical purposes; to the Mississippi State Department of Health Pharmacy for the dispensing of client drugs and invoicing; and to your physician and/or case manager/care coordinator for eligibility determination and service provision/coordination purposes. This application, when filled in, contains patient information that must be protected in accordance with HIPAA. Some information in this application will be supplied to the Medicare/Medicaid office to determine if the client meets medically frail criteria. Medically frail classification will exempt the client from any obligations that may be required to maintain coverage and determine if they are eligible for any other benefits.

_____ Initial & Date

6. Certification of Information:

I, _____, certify that the information contained in this application is complete and correct. I understand that **I must report ANY changes in household size, residency, income, health insurance, and Medicaid status**. I do hereby authorize the release of any necessary information in this application to the entities listed in the *disclosure statement,* above. All information will be treated with the strictest confidentiality.

I understand that I must update my case record biennially by contacting my case manager or by submitting the required documentation to the address or secured email below.

_____ _____
Applicant's signature Date signed

_____ _____
Witness's signature (*If applicant signs with an X*) Date signed

Please forward this application to:
Mississippi State Department of Health
Ryan White Office
P O Box 1700
Jackson, MS 39215-1700

Secured email RyanWhite.PartB@msdh.ms.gov

Office Use Only:

Application approved by:

Name _____ Date _____

Name _____ Date _____

HIPAA: AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

Section A: Must be completed for all authorizations.
I hereby authorize the use or disclosure of my individually identifiable information as described below.

I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or a health care provider, that the organization may also disclose my health information. If this happens, I understand that my information may no longer be protected by federal privacy regulations.
Patient name: _____ ID Number: _____
Persons/Organizations authorized to release/receive information includes:
_____
Persons/Organizations authorized to exchange information includes: **Mississippi State Department of Health, Division of Epidemiology and Health Planning, Infectious Disease Branch, HIV/AIDS Section, Medicare/Medicaid** _____
Specific description of information to be disclosed, including date(s): progress notes, medical documentation form, medical history, laboratory test results, medication history, discharge summaries, treatment recommendations

1. **The patient or the patient's representative must read and initial the following statements:**
   a) I specifically authorize _____ (Agency Name) to release to _____ data and information relating to:
      - **Substance Abuse** (alcohol/drug testing and treatment) Initials:_____
      - **Mental Health** (psychological testing and treatment) Initials:_____
      - **HIV-Related Information** (testing and treatment) Initials:_____

   b) I understand that this authorization will expire (date) _____ Initials:_____
   c) I understand that I may revoke this authorization at any time by notifying _____ (Agency Name) in writing. If I do revoke this authorization, my revocation will not have an effect on any actions the _____ (Agency Name) took in reliance upon my authorization before it received my revocation. Initials:_____
2. **To be completed by the case manager/care coordinator (check only one):**
   a) _____ (Agency Name) will not condition your services on your completing and signing this authorization. ☐
   b) _____ (Agency Name) will condition and not provide services to you because you are not in compliance with program guidelines. ☐

Section B: Must be completed when_____(Agency Name) requests authorization for its own use or for another covered entity to disclose information to_____(Agency Name) for services.
To be completed by _____ (Agency Name).

1. The purpose of the use or disclosure is: to provide case management services _____
2. _____ (Agency Name) ☐ will not receive direct or indirect compensation in exchange for using or disclosing the information listed above.

NOTICE TO PATIENT: You or your representative may inspect and/or copy your individually identifiable information in accordance with _____ (Agency Name) policies and procedures.

Section C: Must be completed for all authorizations.

Patient Name (print): _____Social Security Number: _____

Signature of patient or patient's representative:_____ Date: _____
Name of Patient Representative (print): _____
Witness:_____Date:_____

Informed Participation Agreement

Description of Ryan White Services Program:
Administered by the Ryan White | ADAP, a part of Care and Services at the Mississippi State Department of Health, the Ryan White Services Program is more than a drug distribution program, or a program that pays for insurance or medical care. The Ryan White Services Program provides a comprehensive system of care that includes medication, medical care, and essential support services for people living with HIV who are low income, uninsured, or underinsured.

Benefits and Entitlement Counseling:
Case managers can and eligibility specialists assist eligible clients to obtain access to Mississippi's AIDS Drug Assistance Program. The case managers and eligibility specialists will obtain the completed application, supporting documentation, and any insurance information for the client wishing to receive these services.

Client Responsibilities:
- To be treated with consideration, dignity, and respect regardless of age, race, gender identity, economic status, sexual orientation, mode of transmission, disability status, mental status, family status, nationality, ethnic origin, religious beliefs, or political affiliations.
- To treat staff living with HIV/AIDS with consideration, dignity, and respect.
- Clients must provide accurate information and required documentation to complete the initial and application and semi-annual applicable labs for eligibility certification. The client must report any changes in residency or household income immediately.

Dis-enrollment Policies:
Client will be dis-enrolled from the Ryan White Services Program if they:
- Fail to recertify before the designated expiration date;
- Do not meet eligibility requirements;
- Are lost to follow-up; or
- Commit fraud by knowingly and willingly withholding, hiding, or falsifying information in order to qualify and/or remain eligible in the Ryan White Services Program.

When a client is dis-enrolled from the Ryan White Services Program due to violation of program rules or regulations, the provider agency must document:
- The violation;
- The mechanism of re-instatement; and
- Provision to the patient the verbal and written description of the appeal process.

No eligible client(s) may be dis-enrolled from the Ryan White Services Program without the express written approval of the AIDS Drug and Assistance Program Director. *

Client Eligibility Guidelines:
Clients are required to provide proof of, or in some instances attest to, the following eligibility requirements:

- HIV positive status;
- Household income; and
- Resident of the state of Mississippi.

Individuals not eligible for the Ryan White Services Program include:

- Non-residents of Mississippi and
- HIV negative individuals.

Your signature below confirms your intent to participate in the Ryan White Services Program, and that you understand that you must adhere to all policies and guidelines set forth in the Informed Participation Agreement (IPA). You further acknowledge that you received and reviewed a copy of the IPA.

_____ _____
Signature of Client or Designated Representative Date

_____ _____
Signature of Care Coordinator Date

If a Designated Representative is indicated above, complete the following section:

Please Print

Name of Representative_____

Mailing Address_____

Phone Number_____

Client Initials_____

Grievance Procedures

Consumers may express their dissatisfaction with any Ryan White Services Program service in the following manner:

1. The client should discuss the problem directly with the case manager/care coordinator or counselor at the service site the problem/incident occurred within five (5) working days of the incident or time when client/individual became aware of the problem/incident. For accurate record keeping, please record the date and time this discussion occurred, along with the name of the person the problem/incident was discussed with, as this information may prove helpful later.

   If the client is not satisfied with the decision, the client may forward all written materials within twenty (20) working days after receiving the decision/response to AIDS Drug Assistance Program Director:

   Mississippi State Department of Heath
   Ryan White Office
   P O Box 1700, Jackson, MS 39215-1700
   Or email:
   RyanWhite.PartB@msdh.ms.gov

2. A response will be made in writing within ten (10) working days of receiving the grievance materials.

Client Signature: _____ Date: _____

RYAN WHITE PART B SERVICES ELIGIBILITY APPLICATION

AIDS Drug Assistance Program (ADAP)

Residency Self-Attestation Form

I, _____, declare on this date_____ that I currently reside at
(print name)

Street: _____

City: _____

State: _____

Zip Code: _____

☐ The above address is both my physical address and mailing address.

☐ The above address is my physical address; however, I receive mail and/or deliveries at the following alternate address:

Street: _____

City: _____

State: _____

Zip Code: _____

☐ I currently do not have a permanent address and am residing at one of the following:

- A supervised publicly operated shelter designed for temporary living accommodations.
  - Name of Shelter : _____
- A public or private place (friend) not designed for or ordinarily used for regular sleeping accommodations.
  - Specify Place _____

☐ I am currently without shelter

In the future, should there be a change with any of the above criteria, I understand that I must notify the Ryan White Services Program immediately with the attached supporting documentation.

I understand I will be notified by the Ryan White Services Program if any changes affect my eligibility.

_____ _____

Client Signature Date

_____ _____

Witness (if client is unable to sign) Date

RYAN WHITE PART B SERVICES ELIGIBILITY APPLICATION

AIDS Drug Assistance Program (ADAP)

Income Self-Attestation Form

Please check all that apply.

☐ I, _____, declare that I currently have zero income. I am meeting my daily
(print name)

daily living needs by _____.

☐ I, _____, declare that my spouse/partner currently has zero income.
(print name)

☐ I, _____, declare that I receive monthly income from _____
(print name) (source of income)

In the gross amount of $_____.

☐ I, _____, declare that my spouse/partner receives monthly income from
(print name)

_____ in the gross amount of $_____.
(source of income)

In the future, should I receive income, either through employment, Supplemental Security Income (SSI), Social Security Disability, or other means, I understand that I must notify the State Ryan White Part B Services Program immediately.

I understand I will be notified by mail if changes in my income affect my eligibility for services.

_____ _____
Client Signature Date

_____ _____
Witness (if client is unable to sign) Date

RYAN WHITE PART B SERVICES ELIGIBILITY APPLICATION

AIDS Drug Assistance Program (ADAP)

Wages and salaries from **informal employment** without pay stubs (cash earnings, day laborers, etc.)

To whom it may concern:

I verify that _____ has consistent income performing work as_____

_____

_____

Reports earning $_____ per □ day, □ week , □ month, or □ annual

Reviewed Source:	Result
Paystubs/copy of check or earnings statement	
Verification of Employment form or Employer Statement	
Invoices from services provided	
Online payment system statement	
Documents from a financial institution	
Other form of payment verification notice(letter statement indicating payment amount and source)	

I verify that the information provided above is correct and understand that if I have misrepresented my information, I risk being disqualified for the requested services for Ryan White Part B and/or ADAP.

_____ _____

Applicant's signature Date signed

_____ _____

Witness's signature (*If applicant signs with an X*) Date signed

_____ _____

Case Manager / Social Worker Date signed

_____ _____

ADAP Director

RYAN WHITE PART B SERVICES ELIGIBILITY APPLICATION

AIDS Drug Assistance Program (ADAP)

Clinical Services Information Form

Client Name: _____ DOB: _____

SS#: _____ Care Coordinator: _____

This form is to be completed by your medical provider, their office staff, or medical case manager

1. Date of Positive HIV test: _____
2. CD4 Count | HIV Viral Load: Please report the value and test date for all CD4 Count and HIV Viral Load tests administered in the past six months:

Date:	CD4 Cell Count	CD4 %	HIV Viral Load
1.			
2.			
3.			
4.			
5.			
6.			

Medical Provider Information:

First Name: _____ Last Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: (_____) _____ Email: _____

Stamp/Signature: _____ Date: _____

This information is used to enhance and guide medical case management services offered by the Mississippi State Department of Health Ryan White Care and Services Program.

MSDH Ryan White Service
Referral for Services/ Prescriptions
AIDS Drug Assistance Program (ADAP)

Patient Information:

Name: _____

Address: _____

_____

Phone: _____ Sex ☐ F ☐ M ☐ I ☐

SSN: _____ Race: _____ Birthdate: _____

Drug Allergies _____

County where service will be delivered: _____

Reason for referral (check all that apply):

☐ ADAP/ Medication
☐ Pharmacist Consultation HAART Initiation
☐ Pharmacist Consultation ongoing HAART
☐ Home Base

Referring clinic _____

Address _____

_____ Phone # _____

Other (Non-ADAP) medications (OTC, supplements & Herbal)

1. _____
2. _____
3. _____
4. _____

And/Or ☐ See attached for additional Medications

Lab/ Test Results (include date):

Viral Load: _____ copies/ml Date _____

CD4: _____ cells/µl Date _____

HLA B*5701 (ABC): _____ Date _____

Trofile test (MVC): _____ Date _____

☐ **New Patient** ☐ **Change in Treatment** ☐ **No Change/ Refills**

Prescriptions

Drug: Directions:	Strength: Refills (circle one): ____	Quantity: 30 day supply ☐ Discontinue
Drug Directions:	Strength: Refills (circle one): ____	Quantity: 30 day supply ☐ Discontinue
Drug Directions:	Strength: Refills (circle one): ____	Quantity: 30 day supply ☐ Discontinue
Drug Directions	Strength: Refills (circle one): ____	Quantity: 30 day supply ☐ Discontinue
Drug Directions	Strength: Refills (circle one): ____	Quantity: 30 day supply ☐ Discontinue
Drug: Directions:	Strength: Refills (circle one): ____	Quantity: 30 day supply ☐ Discontinue
Drug: Directions	Strength: Refills (circle one): ____	Quantity: 30 day supply ☐ Discontinue

Additional Orders/Follow-up: Issue Medicines Only

_____

_____

_____

Provider Signature _____ **Date** _____

Provider Name Printed: _____

Provider NPI: _____ **Provider DEA:** _____

Provider please email to: ADAP.Services@msdh.ms.gov

ADAP Medication Delivery & Enrollment Selection Form

Dear ADAP Program Recipient:

As a participant in the Ryan White Part B AIDS Drug Assistance Program (ADAP), you may choose how your medications are dispensed. Please complete this one-page form in full and select ONE delivery option below. Incomplete forms may delay medication access.

Client Information

Client Full Name: _____

Date of Birth (DOB): _____ Last 4 of SSN: _____

Enrollment Status (check one):
☐ New to ADAP ☐ Re-Enrolled ADAP ☐ ADAP Insurance Assistance ☐ Other Insurance

Medication Delivery Options (Select One)

☐ Option 1: Pick-Up at County Health Department
Name of County Health Department: _____

☐ Option 2: Mail Order Delivery (Physical Address Only – No P.O. Boxes)
After receiving your first shipment, you must contact the MSDH Pharmacy at least 7 days before refills are due. MSDH Pharmacy Phone: **1-800-264-6635**

Mailing Name (if different): _____
Physical Address: _____
City: _____ ZIP Code: _____
Email Address: _____

☐ Option 3: Delivery to Approved Primary Care Provider
Provider / Clinic Name: _____
Physical Address: _____
City: _____ Phone: _____

Program Acknowledgement

I acknowledge that all Ryan White Part B | ADAP rules and regulations apply to the delivery option selected above. I understand that failure to notify ADAP of changes to my address, insurance, or eligibility status may result in delays or interruption of services.

Print Name: _____

Signature: _____ Date: _____

Questions or Assistance:
- Your MSDH Case Manager
- Your Primary Care Provider or Clinic
- Phone: 601-362-4879
- Email: RyanWhite.PartB@msdh.ms.gov

Ryan White Part B/ADAP
Insurance & Income Self Attestation Form

Continued Ryan White eligibility requires an update to your eligibility annually to remain eligible for Mississippi State Department of Health Ryan White Services. I understand that the United States Government requires verification of all income, insurance status, or residency.

Please check all that apply.

☐I, _____, declaring that I currently have zero income. I am meeting my daily
(print name)
daily living needs by _____.

☐I, _____, declare that my spouse/partner currently has zero income.
(print name)

☐I, _____, declare that I receive monthly income from _____
(print name) (source of income)
in the gross amount of $_____.

☐I, _____, declare that my spouse/partner receives monthly income from
(print name)

_____ in the gross amount of $_____.
(source of income)

Insurance Status

☐	Medicaid	☐	ACA Health Plan (Federal Marketplace Plan)
☐	Medicare A &B	☐	Private Insurance
☐	Medicare Part D	☐	No Insurance

If you have insurance coverage of any kind, please include front and back copies of your insurance cards.

In the future, should any of this information change, I understand that I must notify the State Ryan White Part B Services | ADAP Office immediately.

_____ _____
Client Signature Witness (if Client is unable to sign)

_____ _____
Date Date

Mississippi Insurance Assistance Program (IAP)

Health insurance support for eligible Ryan White clients

What is IAP?

The Mississippi Insurance Assistance Program (IAP) helps eligible clients pay for health insurance premiums so they can access medical care, medications, and essential health services.

Approved Health Plan Options

Your plan is based on your **Federal Poverty Level (FPL)**, determined by **total household income**.

Ambetter Clear Silver – *Walgreens Health + Vision + Dental*
✔️For clients **100%–200% FPL**

Ambetter Complete Gold – *Walgreens Health + Vision + Dental*
✔️For clients **below 100% FPL or above 200% FPL**

Plan Selection

- **100%–200% FPL:** Silver Plan
- **Below 100% or above 200% FPL:** Gold Plan

Eligibility Requirements

All requirements below must be met:

- No current health insurance (private, employer-based, Medicaid, Medicare)
- Enrolled in **Ryan White ADAP** and **eligible and active**
- **Recertified** for the Ryan White ADAP program
- ADAP medications filled through the **MSDH Pharmacy**
- Household income **below 400% FPL**

Enrollment Steps

Complete the insurance assessment:

MISSISSIPPI STATE DEPARTMENT OF HEALTH

Dear Mississippi Insurance Recipient:

You have been enrolled in the MS ADAP --- Insurance Assistance Program (IAP). Please look for an insurance card from Ambetter and a card from ScriptGuideRX. To fill prescriptions (other than your Health Department prescriptions) take both cards to your local pharmacy. If you have any questions please call 601-362-4879.

This is what the card will look like:

570 East Woodrow Wilson • Post Office Box 1700 • Jackson, MS 39215-1700
601-576-8090 • 1-866-HLTHY4U • www.HealthyMS.com

✅**https://americanexchange.com/clients/mississippi/**

When completing the assessment: - Select **"YES"** for the **MSDH referral** question

If unable to complete online, contact **American Exchange**:

American Exchange (Toll-Free): 833-806-8689

ACA Marketplace Enrollment Period

November 1 – January 15

Need Help?

Contact your case manager or clinic staff.

Important: Failure to maintain eligibility or complete recertification may result in loss of insurance coverage.

Mississippi Insurance Assistance Program (IAP)
Mississippi State Department of Health (MSDH)
[MSDH Logo]

MISSISSIPPI STATE DEPARTMENT OF HEALTH

Mississippi Insurance Assistance Program Recipient

AFFIDAVIT OF UNDERSTANDING FOR INDIVIDUALS ENROLLED IN FEDERAL MARKETPLACE HEALTH PLAN

BEFORE INITIALING AND SIGNING, READ THIS DOCUMENT CAREFULLY AND BE SURE YOU UNDERSTAND

RE: Advance Premium Tax Credit Refunds

You are receiving this letter regarding Advance Premium Tax Credit refund checks. Your premiums for medical insurance are being paid by a third party or insurance assistance program through the Mississippi State Department of Health. Due to your receiving insurance through the Marketplace, you may have received tax credits based on your annual income. IRS reconciliation processed the tax credits and sent refunds to those individuals who have overpayment for insurance premiums. I understand that the amount subject to return is due to under-reporting of my annual income to the marketplace. If you receive a refund for insurance premiums, please contact our office at (601)362-4879 or send the check to our office at MSDH, Attn: Carolyn Anderson/ ADAP Program, P.O. Box 1700, Jackson, MS 39215. If you have cashed the advance premium tax credit refund check, contact our office immediately to discuss process. It is very important for continuation of receiving assistance for premium payments for medical insurance. Our office will work with you on this important matter. Please contact us, so that you will not lose coverage for services.

I have completely read this affidavit of understanding. By signing, I agree to the facts and conditions contained herein.

Applicant Name (Print)_____

Applicant Signature _____

Case Manager or ADAP Witness Signature_____