

## HIV Medical Services Only Online Application Guideline

1. Click on the HIV services for clients tab

SSN:

[Click here for application: ISDH Eligibility Application](#)

2. Once you click you will see the below search option:

### HIV

Welcome Brittany Sichtung

#### Enter Search Criteria

ACAPS ID/ HSP ID:

**OR**

SSN:

**OR**

Last Name:  and Date of Birth(mm/dd/yyyy):

(Enter Both Last Name and DOB combination or SSSn only)

***\*Search your clients by either the social security number or their last name and date of birth.\****

3. After you hit enter, you should see a screen like the below:

#### HIVe Services Eligibility

SSN:	<input type="text" value="535022988"/>
Date of Birth:	<input type="text"/>
First Name:	<input type="text"/>
Last Name:	<input type="text"/>
Middle Name:	<input type="text"/>
<small>*Address listed will be used for all program correspondence. If the applicant is not okay with receiving HIV specific mailing, please use the Care Site address for Mailing Address.</small>	
Mailing Address Line1	<input type="text"/>
Mailing Address Line2	<input type="text"/>
Mailing City	<input type="text"/>
Mailing State	<input type="text"/>
Mailing Postal Code	<input type="text"/>
Applying for (required)	<input type="text"/>

4. Fill out every section as if you were doing the current paper application. If there is a red \* by one of the tabs, you have to answer it before it will allow you to save the data.

	<input type="checkbox"/> VA, Tricare and other military health care <input type="checkbox"/> IHS <input type="checkbox"/> Other plan <input type="checkbox"/> No insurance
Housing Status /Status Date	<input type="text"/> Status Date: <input type="text"/> *
Federal Poverty Level	<input type="text"/> *
HIV Status	<input type="text"/> *
Enrollment Status	<input type="text"/> *

5. Once you have entered the client information or checked for accuracy, make sure you select the HIV Medical Services and HIV Services tab across from Applying for and click save data for client. This is the **BIGGEST difference** compared to HSP only application.

Applying for (required)	HIV Medical Services And Hiv Services ▾ *
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6. After you hit save data for client, you will be brought to the certification of understanding page. Please go over this with the client. Then check I agree.

**CERTIFICATION OF UNDERSTANDING**

Please read the statements below and click "I Agree" button below to certify that you understand the terms of this application. A reference to "Program" refers to the Indiana State Department of Health (ISDH) Medical Services Program or any successor program(s).

You can download or print these document(s) for your reference [Notice of Privacy in English](#) [Notice of Privacy in Spanish](#) [Reference Page for Clients](#) [Federal Poverty Guidelines 2017](#)

- I certify that the information in this application is true and accurate to the best of my knowledge. I understand that I may be disqualified from this Program and prosecuted for willfully providing false information.
- I understand that the information requested on this application is for the purpose of determining my eligibility for a federally funded program. The funding is limited and may expire at any time without extended or alternate funds being available.
- I understand and agree to submit periodic information regarding my continued eligibility for participation in the Program, including proof of income, proof of residency, alternate health insurance coverage documentation, re-certification forms, and general update forms provided by ISDH. To facilitate income verification, I authorize ISDH to execute the Internal Revenue Service Form 4506-T on my behalf.
- I agree to notify, or to have my Care Coordinator notify, ISDH of any circumstances affecting my participation in, or eligibility for, the Program. I agree to notify ISDH within thirty (30) days of a change in address and understand that all Program correspondence will be sent to the address I have on file with the ISDH.
- I understand changes in my situation will be evaluated to determine continued eligibility for the Program. I will be notified in writing if I am to be discontinued from any of the Programs.
- I authorize my physician, other health care providers, treatment center, Care Coordinator, third party health insurance administrator, health insurer, employer, or entity under contract with the ISDH to provide claims processing services to release information necessary to determine my eligibility for services or to facilitate Program services.
- I acknowledge that my program benefits may include the payment of premiums by the ISDH to an insurance carrier chosen by ISDH ("the carrier"). In consideration of same, I hereby authorize and direct the carrier to directly reimburse the ISDH for any unused premium payments should my policy with the carrier terminate or be cancelled for any reason, including but not limited to future ineligibility, death, voluntary termination, involuntary cancellation, or termination by operation of law.
- I agree to indemnify and hold the carrier harmless from any and all claims for making premium reimbursement payments directly to the ISDH or any entity under contract with the ISDH in connection with Program services. I agree to indemnify and hold the ISDH, or any entity under contract with the ISDH in connection with Program services, harmless from any and all claims for receiving premium reimbursement payments directly from the carrier. This agreement shall be binding on my administrators, executors, heirs, successors and assigns and shall remain in full force and effect during the time period in which I am enrolled in the Program. I agree to reimburse the ISDH for any and all premium reimbursement payments that are paid to me in error during my enrollment.
- I authorize the carrier and the ISDH to release information to my physicians, Care Coordinator, other providers, treatment centers, pharmacy benefit managers, state and federal agencies, third party administrators, or health insurers to facilitate provision of Program services. Further, I authorize the carrier and the ISDH to release my enrollment, eligibility, and service utilization records and other information necessary to facilitate provision of Program services to any entity under contract with the ISDH to provide medical or health insurance services, including but not limited to claims processing services.
- I understand that my records are protected under the state law (16-41-8-1) relating to confidentiality of medical or epidemiological information involving a communicable disease (410 IAC 1-2.1) and/or under the federal regulations governing confidentiality of alcohol and drug use Patient Records, 42 CFR Part 2, and cannot be disclosed to any other entity except those referenced herein without my written consent.
- I authorize the ISDH to contact the Alternate Contact Persons listed within this application or any subsequent enrollment record amendment when unable to contact me.
- I understand that I may revoke this authorization at any time in writing. However, the release shall remain valid until such time as I inform the administrator of the Program, in writing, of my wish to terminate services in the federally funded Program, or until such time as I no longer qualify for these services, whichever occurs first, except to the extent that action has been taken in reliance on this authorization.
- A copy of this authorization has the same effect as an original.

7. Once you get to the uploading file page, please remember that you should include the paper application in full, as well as supporting eligibility documents. The things to be uploaded are listed below as reminders.

## File(s) to Upload to ISDH.

### Upload File(s)

Note: The following file types are accepted: pdf, png, gif, jpg, and tif.

\*More information related to acceptable documents can be found on the application.

Documents needed 1. Income – Federal Tax Return, W2, Pay Stubs, SSDI Statement, etc.

2. Residency – Indiana State Issued ID or Driver's License, Full-Year Indiana Resident Tax Return, Cancelled Rent Receipts,

3. Proof of HIV+ Status (HIV Confirmation Certification) 4506 - T Tax Form

4. Third Party Payer Information (Private Insurance, Medicare, Medicaid, etc.)

5. Third Party Payer Information (Private Insurance, Medicare, Medicaid, etc.)

6. Proof of Medicaid or Healthy Indiana Plan (HIP 2.0) (this only applies if the applicant is uninsured and/or applying for the HI Program)

You will need to save each required document or scan directly into your computer and upload each one individually. The system will not take one large file!

#### Upload File:

 

8. If you need the full application, you can find the word document in HIVE. We are working on creating a fillable PDF, but until that happens, please use the word application.

 SSN:  Click here for application: [ISDH Eligibility Application](#)

9. You will see the documents you uploaded listed below the page, the date and time it was uploaded, and who uploaded it. If you have support staff that upload things for Non-Medical Case Managers, please make sure that the NMCM/CC that should be contacted if there is missing information is the one listed in the Care Coordinator Name slot.

Care Coordinator Name (required)

10. After you have uploaded all the needed documents, **YOU ARE DONE!** There is not a submit button, or a final check button. Just make sure your documents are uploaded and the application is for HIV services only.

**Files in the database for this client (click the file name to view)**

Untitled.jpg Upload Date: 3/17/2020 11:36:26 AM , Uploaded by: Raj Pulikal

### **Reminders:**

1. **You must have the full application uploaded.** Enrollment specialist use information in the packet to enroll clients.
2. Eligibility documents to be uploaded
  - a. **Proof of Status**
    - i. Lab report that shows a detectable HIV viral load
    - ii. Lab report that shows positive confirmatory HIV testing
    - iii. Hospital Discharge Summary
    - iv. Notification or verification from physician
  - b. **Proof of Income**
    - i. U.S. Individual Income Tax Return
    - ii. Pay Stubs– 60 days
    - iii. W-2 form(s) – Must be for the most recent prior tax year
    - iv. Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) benefits notification
    - v. Workforce Development form
  - c. **Proof of Residency**
    - i. Indiana Driver's License or State ID
    - ii. Utility Bill
    - iii. Indiana Tax Return
    - iv. Mortgage or lease/rental agreement
    - v. Letter from homeless shelter
    - vi. Immigrant Exception Statement
  - d. **Medicaid application proof**
  - e. Payer of Last Resort form **(recommended not required)**
  - f. Medicaid verification form **(recommended not required)**

FPL formula calculation:

1. You are used to doing this with an HSP only application, but just a reminder that this website: <https://www.needymeds.org/poverty-guidelines> is a great resource for figuring our FPL.
2. You can always reach out to the MSP staff for guidance on tricky income situations. We are here to help!