

INSURANCE SERVICES PROGRAM MONTHLY SERVICE REQUEST

Date of Service Request: _____

(Please Note Benefit Levels: Clients enrolled in the Insurance Services Program are eligible to receive up to **\$400/month for health insurance premiums** and up to **\$175/month for prescription drug co-payment fees**. If a client uses less than the maximum benefit per month, the unspent funds will be reallocated to wait-listed program clients at the end of the month. Premium payment needs in excess of \$400/client/month will be reviewed on a case-by-case basis).

My client _____ RWIS # _____ *residing in zip code* _____ and social security number _____ is either enrolled in the *Insurance Services Program* administered by The Health Councils, Inc., *OR* he/she is wait-listed for program services.

I have submitted a copy of my client's RWIS consent form to The Health Councils, Inc.

My client is (check one): on HIV drug therapy not on HIV drug therapy

My client has income less than or equal to 400%FPL: Yes No

The last documented date on which I had contact with my client was: _____

SERVICES REQUESTED THIS MONTH			
HEALTH INSURANCE		PRESCRIPTION DRUG CO-PAYMENTS	
Premium Amount Requested:	\$	Drug Co-Payment Requested:	\$
Insurance Company:		Pharmacy: (Address & Fax #):	
Make Payment To:			
Mail Payment To:			
Coverage Period:			
Policy Number:			

Signature below attests that I have had documented contact with my client within the last 60 days, and that I intend to continue to have contact with him/her at least every 60 days to keep him/her eligible for ISP services. *My signature also attests that I have submitted a copy my client's RWIS consent form to The Health Councils.*

CASE MANAGER'S SIGNATURE

AGENCY

PHONE #

FAX #

PLEASE RETURN BY MAIL OR FAX TO:
The Health Councils, Inc. Attention: Barbara Hay
9600 Koger Boulevard, Suite 221 St. Petersburg, Florida 33702 FAX (727)570-3033