

**ENROLLMENT APPLICATION FOR MEDICARE PART-D ASSISTANCE
INSURANCE SERVICES PROGRAM**

Date of Enrollment Request: _____

My client _____ RWIS # _____ residing in zip code _____ is a **MEDICARE PART-D RECIPIENT** who is requesting assistance for premium or prescription drug co-payment support through the *Insurance Services Program* administered by The Health Councils, Inc. My client meets the following eligibility criteria for program access:

- He/she is HIV+ with symptoms OR has AIDS.
- He/she has Medicare Part A, B and D
- He/she does not have a secondary insurance policy providing access to prescription drug benefits

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

I have attached the following documentation on behalf of my client (*Note: Applications without the required documentation will not be accepted*):

- RWIS consent form
- Copy of client's health insurance policy benefit summary, including a description of pharmacy benefits

CAUTION: Please advise your client that premiums and/or co-payments made using ISP funds do not count toward the 'TrOOP' (or True Out of Pocket costs) that must be incurred by Medicare Part-D recipients in order to become eligible for catastrophic coverage.

CLIENT DEMOGRAPHICS							
<i>(please insert numerical codes as specified by Hillsborough County Government)</i>							
Social Security Number		Gender	Ethnicity	Race	Income	Housing/Living Arrangements	
Medical Insurance		HIV/AIDS Status	Enrollment Status	DOB		Exposure	
CLIENT INFORMATION							
COUNTY OF RESIDENCE (<i>check one</i>):							
<input type="checkbox"/>	Hardee	<input type="checkbox"/>	Highlands	<input type="checkbox"/>	Manatee	<input type="checkbox"/>	Pinellas
<input type="checkbox"/>	Hernando	<input type="checkbox"/>	Hillsborough	<input type="checkbox"/>	Pasco	<input type="checkbox"/>	Polk
ESTIMATED ANNUAL SERVICE NEEDS							
HEALTH INSURANCE			PRESCRIPTION DRUG CO-PAYMENTS				
Premium Payment Per Month	\$		Drug Co-Payments Per Month	\$			
x 12 months		12	x Estimated Number of Months Needing Medicare Part-D Assistance				
Estimated Total Premiums	\$		Estimated Total Co-Payments	\$			

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 Insurance Services Program services. My signature also attests that - *if the RWIS system is in place on this date* - I have attached a copy my client's RWIS consent form to this application for use by The Health Councils, Inc. My client's co-payment invoice is attached to this initial request for service.

CASE MANAGER'S SIGNATURE _____

AGENCY _____

PHONE # _____

FAX # _____

PLEASE RETURN BY MAIL OR FAX TO:

The Health Councils, Inc. Attn: Barbara Hay 9600 Koger Blvd - #221 St. Petersburg, FL 33702 FAX (727)570-3033