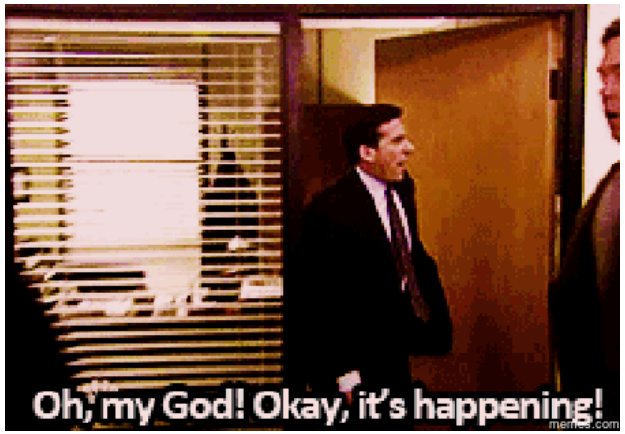
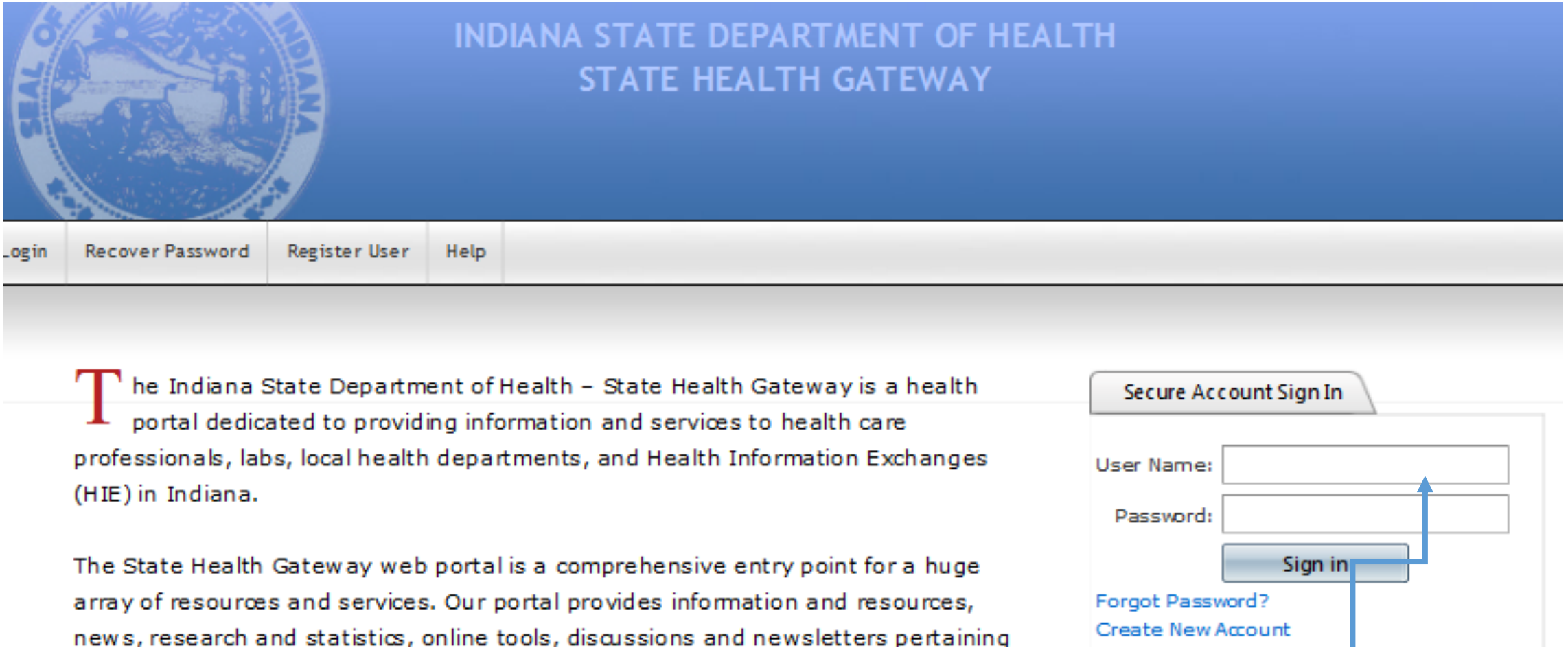
Uploading New MSP Applications



Indiana State Department of Health

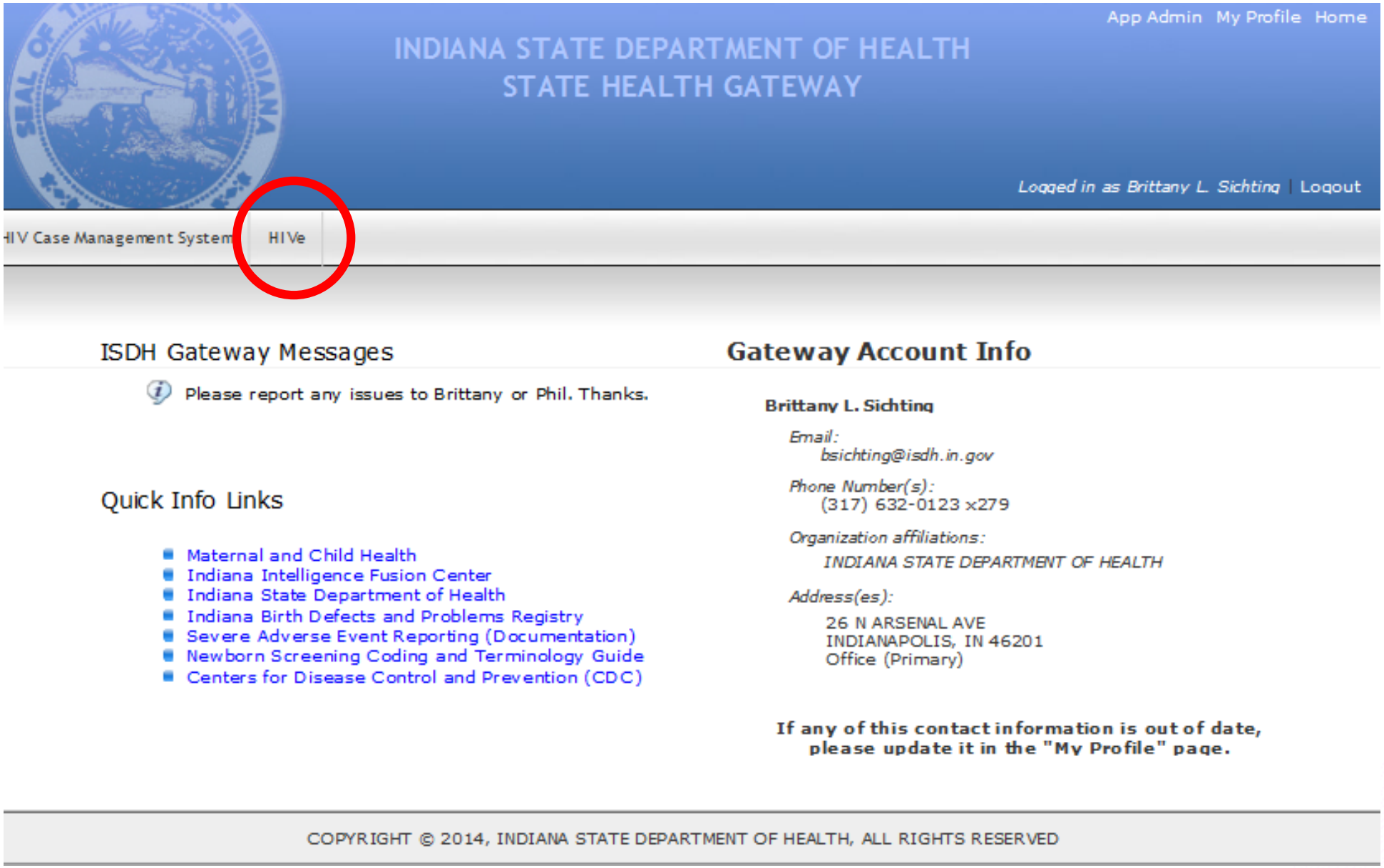
How do I enter and upload a new MSP (ADAP, MDAP, HIAP, HIP) Application?

Indiana State Department of Health



First Log In

Indiana State Department of Health



Indiana State Department of Health

The list of authorized users for this care site is given below, If you notice a user, who is no long
with details.

View Client Data SSN:

Transfer Client to this site

Hiv Services for Clients Click here for application: ISDH Eligibility Application

SQL Reports

Indiana State Department of Health

HIV

Welcome Brittany Sichting

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)

Verify Eligibility

Client Eligibility Reports

Indiana State Department of Health

FILL IN EVERYTHING!

HIVe Services Eligibility

* fields are required fields

Client Id:	
SSN:	*
Date of Birth:	*
First Name:	*
Last Name:	*
Middle Name:	
Sex at Birth: Gender Identity:	* *
Ethnicity:	*
Race	White Black Asian Native Hawaiian/Pacific Islander American Indian or Alaska Native
Race Sub Groups: If Hispanic/Latino : If Asian Race: If Native Hawaiian/Pacific Islander:	
Risk Factor(s)* pick one or more	Male who has sex with male(s) (MSM) Injecting drug use (IDU) Hemophilia/coagulation disorder Heterosexual contact Receipt of blood transfusion, blood components, or tissue Mother w/at risk for HIV infection (perinatal transmission) Risk factor not reported or not identified
Health Coverage* pick one or more	Private – Employer Private – Individual Medicare Medicaid, CHIP or other public plan VA, Tricare and other military health care IHS Other plan No insurance/uninsured
Housing Status /Status Date	Status Date: *
Federal Poverty Level	*

Enrollment Status	*
HIV Diagnosis Year(YYYY)	*
*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.	
Mailing Address Line1	*
Mailing Address Line2	
Mailing City	*
Mailing State	*
Mailing Postal Code	*
Applying for (required)	*
Care Site (required)	*
Care Coordinator Name (required)	
Remarks :	

Save Data for Client

Indiana State Department of Health

MOST IMPORTANT CHANGE!

THEN HIT → Save Data for Client

Indiana State Department of Health

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 dowload 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

1. 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.
2. 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.
3. 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.
4. 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.
5. 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.
6. 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.
7. 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.
8. 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.
9. 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.
10. 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.
11. 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.
12. 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.
13. A copy of this authorization has the same effect as an original.

I Agree

Indiana State Department of Health

Document Uploading Time

File(s) to Upload to ISDH.

Upload File(s)

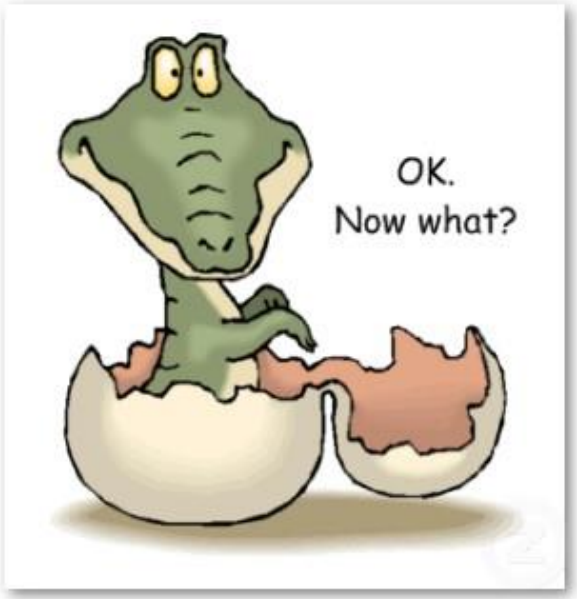
Note: The following file types are accepted: pdf, png, gif, jpg, and tif.
*More information related to acceptable documents can be found on the application.
Reminders:

1. **You must have the full application uploaded.** Enrollment specialist use information in the packet to enroll clients.
2. Eligibility documents to be uploaded
   1. **Proof of Status-Examples**
      1. Lab report that shows a detectable HIV viral load
      2. Lab report that shows positive confirmatory HIV testing
      3. Hospital Discharge Summary
      4. Notification or verification from physician
   2. **Proof of Income-Examples**
      1. U.S.Individual Income Tax Return
      2. Stubs–Pay 60 days
      3. W - 2 form(s) – Must be for the most recent prior tax year
      4. Supplemental Security Income(SSI) or Social Security Disability Insurance(SSDI) benefits notification
      5. Workforce Development form
   3. **Proof of Residency-Examples**
      1. Indiana Driver's License or State ID
      2. Utility Bill
      3. Indiana Tax Return
      4. Mortgage or lease / rental agreement
      5. Letter from homeless shelter
      6. Immigrant Exception Statement
   4. **Payer of Last Resort form**
   5. **Medicaid verification form**

Important note: Make the location of the file path smaller Example C:\mydocuments\client\clientxxx and File name small and meaningful and with no special characters like * &etc; Otherwise you may get fiile upload error.

Upload File:
Choose File No file chosen

Indiana State Department of Health



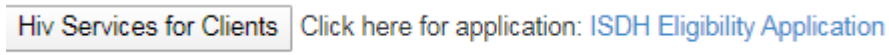
Reminders

1. You must have the whole application uploaded as well as supporting documents.
2. During the state of emergency we will take a word document stating that the client is making a certain amount, and that the NMCM affirms they are eligible.
3. Once you submit your files, you are done.
4. You will get an email confirming your application is received.
5. If more information is needed in the application, one of the enrollment specialist will reach out to the NMCM/CC listed on the application.

Eligibility Reminders

Indiana State Department of Health

What do I need to upload?

- You must have the full eligibility application uploaded.
  - You can find the fillable PDF in HIVe. 

- Try and upload as many eligibility documents as possible.
- During the state of emergency, we understand that all documents may not be able to be gained.
  - If the client can snap a picture and send to you great!
  - If not, we will take a word document from the NMCM/CC stating the client is enrolled during the COVID-19 outbreak, and you are taking on the full responsibility with the clients eligibility for the program.
  - Documents will need to be upload within 60 days.

What makes someone eligible?

- At or below 300% of poverty level
- HIV Positive
- Indiana Resident
- Payer of last resort form
- Medicaid form
- 4506-T (recommended, not required)

Indiana State Department of Health

Common Income Documents

- U.S. Individual Income Tax Return
- Pay Stubs– Must be most recent
- W-2 form(s) – Must be for the most recent prior tax year
- Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) benefits notification

Indiana State Department of Health

Common Residency Documents

- Indiana Driver's License or State ID
- Utility Bill
- Indiana Tax Return
- Mortgage or lease/rental agreement
- Letter from homeless shelter
- Immigrant Exception Statement

Indiana State Department of Health

Common HIV Status Documents

- Lab report that shows a detectable HIV viral load
- Lab report that shows positive confirmatory HIV testing
- Hospital Discharge Summary
- Notification or verification from physician

Indiana State Department of Health

This is a new form eft. 11/1/18- this is to show that clients understand the importance of applying for Medicaid. If the client is already on Medicaid, then just check that box.

HIV Services Program Medicaid Verification Form

By checking the box below, you confirm that you are applying for Indiana Medicaid. Persons who may be eligible for Medicaid but do not apply for Medicaid coverage may be ineligible for Ryan White-funded services. The application process may require more information, which you also agree to provide in a timely manner. ☐

First Name: Click here to enter text.

Last Name: Click here to enter text.

Date of Birth:Click here to enter text.

Social Security Number:Click here to enter text.

Date of Medicaid Application:Click here to enter text.

Care Coordination Site : Click here to enter text.

Care Coordinator : Click here to enter text.

Contact Phone Number: Click here to enter text.

Upon application to any Medicaid program, the Indiana Family and Social Services Administration (FSSA) has 45 days to review all new applications, as well as re-applications. The table below is to track each step of the application process. Please include the date, action plan, and any other notes in regards to the application process. The follow up documents showing Medicaid approval, denial, or pending status must be included with this form to document the application process. If clients are approved for Medicaid, a Report of Change needs to be submitted to spenrollment@ishd.in.gov to remove them from HIV medical services.

Date	Action/Items Needed	Follow Up/Notes

By checking this box, you are verifying that the applicant does not meet the income regulations for Medicaid OR they are already on a Medicaid program. ☐

Applicant's Signature:	
Date:	

This is a new form eft. 11/1/18- this is to show that clients understand that Ryan White funding is the payer of last resort. IF there is other coverage like Medicaid, employer insurance, or other that the client can use, that is to be used prior to RW funding.

Health Care Coverage Enrollment Checklist

All Indiana funded Case Management sites will vigorously pursue enrollment into health care coverage for individuals who may be eligible for Medicaid, Medicare, employer-sponsored health insurance coverage, Qualified Health Plans through the Marketplace and/or other private health insurance and will document efforts in client file (ISDH HSP Policy #18-03: "Vigorously Pursuing Client Health Care Coverage Enrollment Policy"). Documentation that Case Managers have vigorously pursued other health coverage will include copies of or notes in the client's file. Clients must place their initials beside each category to verify its completion:

- Screening for coverage eligibility for other health coverage. _____
- Proof that the client is not eligible to obtain other health coverage, including but not limited to proof of an exemption. _____
- Detailed efforts to educate the client about other health coverage options including Medicaid, Medicare, employer-sponsored health insurance coverage, Qualified Health Plans through the Marketplace and/or other private health insurance, etc. _____
- Informational letters, brochures, or other materials provided to the client to educate about other health coverage options. _____
- Client's acknowledgement of education and their decision about enrollment. _____
- Detailed efforts to enroll/apply or referral for assistance with enrollment/applications for other health coverage options including Medicaid, Medicare, employer-sponsored health insurance coverage, Qualified Health Plans through the Marketplace and/or other private health insurance, etc. Clients will be screened during the annual and semi-annual eligibility recertification process for eligibility for other types of health coverage (or any other alternative payment source). All clients must be informed about all possible health coverage available and the consequences (including possible penalties and financial impact) for not applying/pursuing health coverage. This includes financial checks that may be sent to clients for retroactive payment while enrolled in the Ryan White Program. Initialing this box enforces the requirement to return checks to ISDH. _____

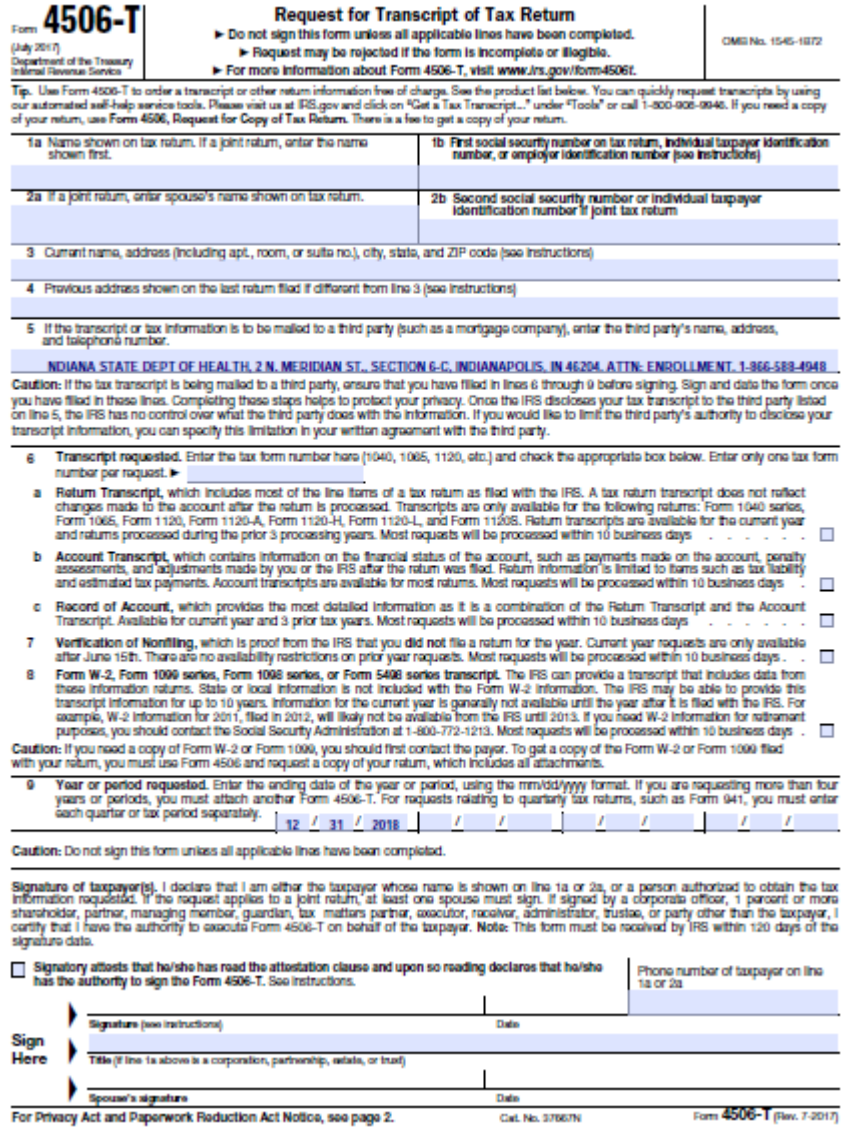
I have been provided with all of the above listed information regarding my health coverage choices:

Client Signature: _____

Case Manager's Signature for Verification: _____

Draft

The 4506-T is not required, but recommended for use during an HSP application. This form allows us to get up to date reported income on clients.



Form **4506-T**
(July 2017)
Department of the Treasury
Internal Revenue Service

Request for Transcript of Tax Return
► Do not sign this form unless all applicable lines have been completed.
► Request may be rejected if the form is incomplete or illegible.
► For more information about Form 4506-T, visit www.irs.gov/form4506t.

OMB No. 1545-1872

Tip. Use Form 4506-T to order a transcript or other return information free of charge. See the product list below. You can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Get a Tax Transcript..." under "Tools" or call 1-800-908-9946. If you need a copy of your return, use **Form 4506, Request for Copy of Tax Return.** There is a fee to get a copy of your return.

1a Name shown on tax return. If a joint return, enter the name shown first.	1b **First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)**
2a If a joint return, enter spouse's name shown on tax return.	2b **Second social security number or individual taxpayer identification number if joint tax return**

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)

4 Previous address shown on the last return filed if different from line 3 (see instructions)

5 If the transcript or tax information is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number.

INDIANA STATE DEPT OF HEALTH, 2 N. MERIDIAN ST., SECTION 6-C, INDIANAPOLIS, IN 46204, ATTN: ENROLLMENT, 1-866-588-4948

Caution: If the tax transcript is being mailed to a third party, ensure that you have filled in lines 6 through 9 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy. Once the IRS discloses your tax transcript to the third party listed on line 5, the IRS has no control over what the third party does with this information. If you would like to limit the third party's authority to disclose your transcript information, you can specify this limitation in your written agreement with the third party.

6 **Transcript requested.** Enter the tax form number here (1040, 1065, 1120, etc.) and check the appropriate box below. Enter only one tax form number per request. ►

a **Return Transcript,** which includes most of the line items of a tax return as filed with the IRS. A tax return transcript does not reflect changes made to the account after the return is processed. Transcripts are only available for the following returns: Form 1040 series, Form 1065, Form 1120, Form 1120-A, Form 1120-H, Form 1120-L, and Form 1120S. Return transcripts are available for the current year and returns processed during the prior 3 processing years. Most requests will be processed within 10 business days . . . . . ☐

b **Account Transcript,** which contains information on the financial status of the account, such as payments made on the account, penalty assessments, and adjustments made by you or the IRS after the return was filed. Return information is limited to items such as tax liability and estimated tax payments. Account transcripts are available for most returns. Most requests will be processed within 10 business days . ☐

c **Record of Account,** which provides the most detailed information as it is a combination of the Return Transcript and the Account Transcript. Available for current year and 3 prior tax years. Most requests will be processed within 10 business days . . . . . ☐

7 **Verification of Nonfiling,** which is proof from the IRS that you **did not** file a return for the year. Current year requests are only available after June 15th. There are no availability restrictions on prior year requests. Most requests will be processed within 10 business days . . ☐

8 **Form W-2, Form 1099 series, Form 1098 series, or Form 5498 series transcript.** The IRS can provide a transcript that includes data from these information returns. State or local information is not included with the Form W-2 information. The IRS may be able to provide this transcript information for up to 10 years. Information for the current year is generally not available until the year after it is filed with the IRS. For example, W-2 information for 2011, filed in 2012, will likely not be available from the IRS until 2013. If you need W-2 information for retirement purposes, you should contact the Social Security Administration at 1-800-772-1213. Most requests will be processed within 10 business days . ☐

Caution: If you need a copy of Form W-2 or Form 1099, you should first contact the payer. To get a copy of the Form W-2 or Form 1099 filed with your return, you must use Form 4506 and request a copy of your return, which includes all attachments.

9 **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than four years or periods, you must attach another Form 4506-T. For requests relating to quarterly tax returns, such as Form 941, you must enter each quarter or tax period separately. 12 / 31 / 2018

Caution: Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax information requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506-T on behalf of the taxpayer. **Note:** This form must be received by IRS within 120 days of the signature date.

☐ **Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506-T.** See instructions.

Phone number of taxpayer on line 1a or 2a

Sign Here

Signature (see instructions) | **Date**

Title (if line 1a above is a corporation, partnership, estate, or trust)

Spouse's signature | **Date**

For Privacy Act and Paperwork Reduction Act Notice, see page 2. Cat. No. 37667N Form **4506-T** (Rev. 7-2017)