

2010 Bridging The Gap, Colorado Application

Bridging the Gap, Colorado
Colorado Department of Public Health and Environment
Phone: (303) 692-2783
FAX: (303) 782-5393



State Pharmaceutical Assistance Program

Bridging The Gap, Colorado (**BTGC**) is a State Pharmaceutical Assistance Program (SPAP) that provides premium assistance and medication coverage for qualified individuals with Medicare Part D Prescription Drug Plans (PDP), or Medicare Advantage Plans (Part C). **BTGC** will assist with Medicare C or D premium and prescription drug expenses on your chosen plan, such as deductibles, co-insurance, “coverage gap”, and catastrophic level payments for medications *that are also* on the Colorado AIDS Drug Assistance Program (ADAP) formulary. You must also sign a release of information that allows BTGC and its contractors to perform functions related to the payment of these fees to your drug plan, through the Centers for Medicare and Medicaid Services (CMS), and its agents.

PLEASE READ CAREFULLY BEFORE SIGNING

- *I understand that **Bridging the Gap, Colorado (BTGC)** is solely funded by money received from funding provided by the Colorado Assembly. Participation in the program and scope of services covered are dependent upon the availability of funds.*
- *I understand that I must meet certain Colorado ADAP eligibility criteria in order to receive BTGC benefits, including Colorado residency. I agree to submit eligibility documentation upon request, at least once per year. If, at any point during the year, I am found by Colorado ADAP to no longer meet eligibility criteria, my BTGC benefits will also cease.*
- *I understand that by participating in BTGC, I will receive assistance with premium payments and/or pharmaceutical co-payments to cover costs related to maintaining my Medicare Part C or D policy. I understand that I must reimburse BTGC for any money received by me (through refund or other means) or paid on my behalf to which I was not entitled.*
- *I understand that I must apply for any and all Low Income Subsidy programs that may be available to me, and that failure to do so may make me ineligible for BTGC or other assistance from Colorado ADAP.*
- *I agree to report any changes in my circumstances to BTGC, including changes in insurance coverage, insurance premium, my phone number and my address.*
- *I assume full responsibility for the accuracy of the statements on this form. I understand that the Colorado Department of Public Health and Environment will use these statements to determine my eligibility for BTGC. I also understand that Colorado laws stipulate that anyone who obtains or tries to obtain or who helps any person to obtain public assistance to which the person is not entitled is guilty of violating the laws of the State of Colorado.*
- *In order to participate in **BTGC**, I understand that I **must** sign a release of information stating that the Colorado Department of Public Health and Environment or its agents will communicate information to the Centers for Medicare and Medicaid Services (CMS) and with my Prescription Drug Plan in order to assure the proper application of monies paid on my behalf to the Prescription Drug Plan I have chosen.*
- *I understand that information about **BTGC** will be mailed to my address, including updates about my eligibility and program changes and services.*

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The information on this form will be used in determining eligibility for the Colorado State Pharmaceutical Assistance Program, Bridging the Gap, Colorado. The form must be signed by the applicant (or the applicant's representative).

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Section 3 – Low Income Subsidy Information

Please answer the following questions about low income subsidy (extra help):

- 1) In the last 12 months what was your annual income? \$ _____
(Include your spouse's income, if you're married)
- 2) Have you applied for a low-income subsidy (extra help) from the Social Security Administration? Yes No

If your answer to question (1) is less than \$16,200 for one person (or \$21,400 for you and your spouse), you may qualify for a low-income subsidy (extra help) from the federal government. If your income meets these criteria, and you answered "no" to question (2), before you can be eligible for BTGC you must apply for low income subsidy by calling 1-888-696-7213 locally, or calling Social Security at 1-800-772-1213.

If you answered "yes" to question (2), please check which of the following is true for you:

- Approved, 100% Assistance
 Approved, partial assistance (attach copy of approval letter)
 Denied Assistance (attach a copy of pre-decisional or denial letter)
 Awaiting decision, application date: _____

Section 4 – Documentation

Do you have the following documentation? If so, please attach it to your application to help us process your application as quickly as possible:

- A copy of your Medicare Part D Card No, I don't have this Yes, I have attached this
- A statement from your insurance company showing the amount of your 2010 Medicare Part D premium if you are requesting that BTGC pay it No, I don't have this Yes, I have attached this
 I am not requesting help with premium payments

Consent to Participate and Consent to Release Personal and Medical Information

The AIDS Drug Assistance Program (ADAP) and the State Pharmaceutical Assistance Program – Bridging the Gap, Colorado (BTGC) are assistance programs administered by the Colorado Department of Public Health and Environment (CDPHE) to provide prescription drug treatments to persons infected with Human Immunodeficiency Virus (HIV). All items contained in the **ADAP Certification and Authorization of Release of Information form** applies to the BTGC program.

Client Eligibility

Individuals applying for ADAP or BTGC services must meet eligibility standards. **Please note that any listed eligibility standards as well as amount of assistance available may be adjusted at any time. All programs at CDPHE are not an entitlement and are based on available funding.** As of November 1, 2009, services are only available to persons who reside in Colorado, do not have private health coverage with prescription benefits, and have a Federal adjusted gross income below 400% of Federal Poverty Level. To verify eligibility for this program, CDPHE, or its agents may be required to obtain personal information from other agencies or health care providers.

If you agree to take part in the AIDS Drug Assistance Program or Bridging the Gap, Colorado, the enrollment coordinator will collect personal information including your name, date of birth, address, social security number, Medicare Prescription Drug Plan information, and financial eligibility for the program. The information will be

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considered confidential, but may be released to your BTGC participating pharmacy, essential case enrollment coordination staff, employees of Ramsell Public Health Rx (the BTGC pharmacy benefits manager), and the Centers for Medicare and Medicaid Services and its agents for the sole purpose of administering the program and for paying your Medicare Part D prescription drug benefits.

Any professional or other reports that may be published to comply with reporting requirements to grantors such as the state or federal government will not use your name or any personal identifying information. Other than as described above for the purpose of administration of the ADAP Program, all client information is kept confidential unless disclosure is specifically consented to by the client, or is otherwise allowed by law.

Consent

I, _____, consent to release of personal and medical information as described above to CDPHE, Ramsell Public Health Rx, the Centers for Medicare and Medicaid Services, and other governmental or public agencies as necessary to determine my eligibility for ADAP services and for the coordination of my pharmacy benefits under my chosen Medicare Advantage or Prescription Drug Plan. I understand that pursuant to the Colorado Governmental Immunity Act, C.R.S. § 24-10-101 *et seq.*, the CDPHE is not liable for damages for any injury arising out of my participation in this program.

This consent shall remain in effect for two years from the date of my signature below unless revoked by me in writing. A photocopy of this signed consent shall be considered as valid and may be relied upon by the agencies participating in this program.

Client Signature: _____

Client Name: _____ **Date:** _____

Witness Name: _____ (if not signed by applicant)

Witness Title: _____

Witness Signature: _____ **Date:** _____

Return this application to:
CDPHE HIV Care and Treatment Program
BTGC A3 -3800
4300 Cherry Creek Dr. South, Denver, CO 80246
Telephone: (303) 692-2716 Fax: (303) 782-5393