Florida HIV Patient Care Eligibility Manual

Contents

SECTION 1: General Information

Purpose

Florida Department of Health (FDOH) HIV Section patient care programs include the Florida State Housing Opportunities for Persons with AIDS (HOPWA) Program and the Ryan White Part B Program, which includes the Florida AIDS Drug Assistance Program (ADAP) and the General Revenue Patient Care Network. These programs are responsible for ensuring services are provided to those intended by establishing eligibility requirements and procedures that will be fairly applied to all who request services.

Authority

Florida Statutes sections 384.29 and 456.057 and the Health Insurance Portability and Accountability Act are the guiding authorities for FDOH security policies and HIV patient care eligibility requirements. This manual is developed in conjunction with the eligibility requirements in Chapter 64D-4, Florida Administrative Code (FAC). Staff must take careful and reasonable steps to protect applicant/client confidential information by adhering to the statutes and determining eligibility per Chapter 64D-4, FAC, hereafter referred to as the "eligibility rule."

Confidentiality Policy and Procedure

All written and verbal communications with applicants during and after eligibility determination must be maintained in strict confidence as required by law. These procedures are the same for eligibility and case management agencies. FDOH has written security policies, protocols and procedures to ensure the security of information. To protect confidentiality, data integrity and access to information, FDOH has created DOHP 50-10, "Information Security and Privacy Policy." To request a copy of DOHP 50-10, lead agencies can contact their local FDOH contract manager. Contracted and subcontracted providers for FDOH HIV programs may create their own security policies, protocols and procedures; however, they must be consistent with DOHP 50-10.

All employees and volunteers with access to client information must receive annual training on confidentiality, the proper exchange of information and required consent. Documentation of training must be maintained in personnel records.

SECTION 2: Eligibility Process

This section explains the steps for new applicants seeking services for HIV patient care programs under the eligibility rule, including consortia programs, ADAP and HOPWA.

Application to Receive Allowable Services for HIV/AIDS Patient Care Programs

Applicants who need Ryan White services and have never received Ryan White Part B services in Florida must complete the Application to Receive Allowable Services for HIV/AIDS Patient Care Programs form that is referenced in the eligibility rule. Completion of an application is only required once, upon initial enrollment. To generate a paper version of the Application to Receive Allowable Services for HIV/AIDS Patient Care Programs form, please visit FloridaAIDS.org/patient-care/eligibility-information1.html.

The application is divided into the following parts:

- Applicant Information
- Living Arrangements
- Medicaid Insurance and Other Programs
- Household Monthly Income
- Rights and Responsibilities
- Applicant Signature
- For Eligibility Staff Only (optional)

Applicants may complete the application in its entirety before submitting to eligibility staff or staff may assist the applicant in completing the application during the initial contact. Once eligibility staff receive the application, they must review each section to ensure it is completed properly.

Initial Contact

Initial contact procedures may vary among eligibility providers; however, at a minimum, the following information should be provided:

- Eligibility requirements as stated in the eligibility rule
- Where to obtain the application
- The services available from programs under the eligibility rule
- Time limits for submitting documentation

Please note: Confidentiality issues could be a factor if other individuals in the applicant's household are unaware of the applicant's HIV status. It is very important to contact an applicant only in the manner instructed in Part 2 of the application.

Time Limits

Once the application is received, signed and dated, a determination of eligibility must be made within 30 days. Mail-in applications are dated when received by the eligibility provider.

- Walk-in applicants who submit a completed or partially-completed application will have their application dated the same day.
- Online submission of the application is dated the date of submission.
- If eligibility documentation has not been received within 30 days, the time limit can be extended with supervisory approval and documentation.

- At the end of 30 days or the time limit extensions, incomplete applications are considered closed.

Required Documentation in Eligibility Chart

Only one eligibility file per client is required. The following documentation must be included in the file and scanned into the state-approved data system within two business days of receipt:

- Original eligibility application signed and dated by the applicant and staff
- Documentation of presence of HIV
- Documentation of living in Florida
- Documentation of household size
- Documentation of low income
- Copies of any active third-party insurance card, such as Medicare, Medicaid, private insurance or other
- Any additional applicant notes (case notes, housing status, potential language barriers, insurance related concerns, or other)
- Eligibility Staff Assessment Worksheet (if applicable)
- Part A or B Notice of Eligibility (NOE) or Notice of Ineligibility (NOI)
    - An applicant's NOE will be authorized for 366 days (date client is determined eligible plus 365 days)
    - An applicant may complete determination paperwork no more than 30 days in advance of their NOE expiration date.
- Releases and consents signed by the applicant
- Applicant backup documentation for required documents

Types of Eligibility Assessment

There are three categories of eligibility assessments: Initial Eligibility Determination, Eligibility Confirmation and Comprehensive Eligibility Determination.

Initial Eligibility Determination refers to the process for individuals applying for HIV patient care programs for the first time ever within the state of Florida.

Applicants need to provide either a current NOE from a Ryan White Part A program or all of the following:

- Signed application
- Test result confirming presence of HIV
- Proof of living in Florida
- Documentation of household size
- Proof of low income
- Proof of public and/or private insurance policy or insurance waiver

Persons who are determining or confirming eligibility need to do the following:

- Complete the Eligibility Staff Assessment Worksheet (as applicable)
- Screen for public and/or private payer sources
- Complete NOE/NOI, if applicable
- Upload required documentation and forms into the state-approved data system

Eligibility Confirmation refers to the process for individuals to continue receiving HIV patient care program

services by verifying or updating their eligibility criteria. This can be done up to 30 days before or after the NOE expiration date. (Applicants whose NOE has been expired for more than 31 days must complete a comprehensive eligibility determination.)

If any of the following have changed, applicants must provide documentation of the status change. Otherwise, they can attest that there have been no changes by completing the Ryan White Patient Care Core Eligibility Recertification form.

- Living in Florida
- Household size
- Income
- Insurance policy

Persons who are determining or confirming eligibility need to do the following:

- Screen for public and/or private payer sources.
- Complete NOE/NOI.

Ensure completion of a Ryan White Patient Care Core Eligibility Recertification form, including applicant's self-attestation of no change. This may be completed by the applicant or staff and may be used up to 30 days before or after expiration of previous NOE. Upload required documentation and forms into the state-approved data systems.

Comprehensive Eligibility Determination refers to the collection of more in-depth supporting documentation that must be completed bi-***annually***, at a minimum. This is for individuals returning for HIV patient care services.

Applicants whose NOE has been expired for more than 31 days must complete a comprehensive eligibility determination. Please note, applicants returning for HIV patient care program services are not required to resubmit the initial application or provide proof of HIV status, as this is required only during the initial eligibility determination.

Applicants will need to provide the following documentation:

- Proof of living in Florida
- Documentation of household size
- Proof of low income
- Proof of public and/or private insurance policy

Persons who are determining or confirming eligibility need to do the following:

- Screen for public and/or private payer sources
- Complete NOE/NOI
- Upload required documentation and forms into the state-approved data systems

SECTION 3: Criteria

HIV Status

An applicant must have a confirmed-positive test result from a test approved by the Food and Drug Administration to determine the presence of HIV infection.

Acceptable documentation for proof of HIV is:

- HIV antibody or combination antigen/antibody reactive test followed by a subsequent test below:
  - Reactive immunofluorescence assay
  - Reactive HIV-1/2 antibody differentiating immunoassay
- Positive qualitative HIV RNA nucleic acid test (NAT)
- Quantitative HIV NAT (viral load)
- HIV-1 p24 antigen-only test
- HIV-1 indirect fluorescent antibody
- HIV isolation (viral culture)
- HIV nucleotide sequence (genotype)
- Western blot

Acceptable proof of HIV must be presented within 30 days of application date. Otherwise, the applicant is not eligible to receive Ryan White Part B services and should be issued an NOI. Once an applicant can present labs that reflect a positive or detected lab, the applicant may continue the enrollment process.

Exposed Infants
Infants of mothers living with HIV can be served up to the age of 12 months with documentation of the mother's HIV diagnosis. Children 12 months or older must meet the criteria for proof of HIV listed above to receive services.

Living in Florida

For purposes of eligibility, an applicant needs to be currently living in the state of Florida. A specific number of weeks or months in Florida are not required; however, an applicant's intent to remain in Florida is requested and documented, particularly for medical and treatment services. Applicants may have unusual circumstances, such as the unpredictability of migrant work, that require consideration.

Acceptable Documentation for Proof of Living in Florida
(Please note: Documents outside the driver's license, identification card or housing, rental or mortgage agreement must be dated no more than 90 days from determination date.)

- Current Florida driver's license
- Current Florida identification (ID) card
- Most recently filed property tax receipt
- Most recently filed W-2*
- Resident verification statement completed by one of the following:
  - Case manager verifying applicant's homelessness or residency by physically viewing applicant's living arrangements
  - Shelter staff indicating applicant is residing at the shelter
- Claim of support letter*

- Declaration of Domicile
- Supplemental Nutrition Assistance Program (SNAP) print out
- Florida Medicaid Management Information System (FLMMIS) printout or verification*
- Electronic insurance database verification print out
- Self-declaration of homelessness
- Official correspondence postmarked to a physical residential address with name and address
- Utility bill
- Statement from financial institution
- Unemployment document*
- Voter registration card
- Recent jail-/prison-release records
- Corrections offender search website photo print out
- Housing, rental or mortgage agreement
- School records

*Can also be used for proof of income or proof of insurance verification.

Documents submitted by applicant from the approved list must have an address located in Florida and must be current. For example, a Florida driver's license must be valid and not have expired to be deemed acceptable proof.

Acceptable proof of living in Florida must be presented within 30 days of application date. Otherwise, the applicant is not eligible to receive Ryan White Part B services and should be issued an NOI. Once an applicant can present proof of living in Florida, the applicant may continue the enrollment process.

Household Size and Income

Determining Household Size

Household size is the number of persons in an applicant's household, which includes the applicant, the applicant's spouse (if married), all persons the applicant could claim as dependents on their taxes and anyone living with the applicant who could claim the applicant as a dependent on their taxes.

Household size can be documented by any of the following:

- United States Individual Income Tax Return (Form 1040).
  - If someone claims the applicant as a dependent, you will need to count the applicant plus the individual's household to total the household size.
  - If the applicant files as independent but claims dependents, total the individuals listed on the Form 1040 along with the applicant to obtain the total household size.
  - If the applicant files single with no dependents, the household will be a household of one.
- Marriage certificate (if recently married and not eligible to file taxes jointly in most recent tax year). This document provides the name of the applicant and spouse, who are both counted as members of the total household size.
- For dependent(s), birth certificate or guardianship documentation (must be an eligible dependent who will be claimed in the current tax year).

Determining Household Income

Household Income is the aggregated income from all sources received by the applicant, the applicant's spouse

(if married), anyone who lives with the applicant who the applicant can claim as a dependent on their taxes and anyone who lives with the applicant and claims the applicant as a dependent on their taxes. Adults living outside of the household who provide money to the applicant on a daily, weekly or monthly basis are not included in the household size, but the amount of financial support (allowance) is counted.

Gross income is commonly defined as the amount of a person's income before any deductions or taxes are taken. Gross income (both earned and unearned) is the amount used when determining eligibility.

Income Counted
Earned income is compensation earned from participation in a business, including wages, salary, tips, commissions, bonuses, earnings from self-employment and royalties or honoraria. Enough documentation should be collected to reasonably determine a person's annual income to be able to project forward.

Unearned income is all income that is not earned, such as Social Security benefits, pensions, disability payments, unemployment benefits, interest income, rental property income and cash contributions from relatives and third parties.

Income Not Counted
Income that is not counted includes grants, scholarships, fellowships, the value of SNAP/Temporary Assistance for Needy Families (TANF) benefits, 401K funds if not accessed and any other non-accessible income, such as trust funds.

Income can be documented by any of the following:
(Please note: Documents must be dated no more than 90 days from determination date.)

- Tax documents for the current or previous tax year
  - IRS 1040 form
  - 1040 Schedule C or IRS 1099-MSC form
  - IRS W-2
  - IRS 5329
- Copy of recent pay stubs*
- Signed statement of no income*
- Claim of support*
- Child support documentation
- Self-employment tracker sheet
- Retirement pension statement for the current or previous tax year*
- Current letter of award*
  - Supplemental Security (SSI)
  - Social Security Disability (SSDI)
  - Veteran Affairs (VA)
- Rental property documentation
- Corrections Health Services referral*
- Trust or court document reflecting royalties
- Florida Department of Revenue Suntax printout

*Can also be used for proof of living in Florida.

How to Calculate Percent of Federal Poverty Level (FPL)

FPL is a measure of income issued every year by the U.S. Department of Health and Human Services. FPL is used to determine eligibility for certain programs and benefits, including savings on Marketplace health insurance and Medicaid and Children's Health Insurance Program (CHIP) coverage.

The percent of FPL must be calculated to a specific number, rather than a range, by doing the following:

- Determine household size.
- Determine household annual income.
- Use the household income and the FPL guidelines listed in the eligibility rule to determine the percent of FPL for the applicant.

How to Calculate Household Annual Income

Circumstances may vary based on the availability of documentation. Below are some examples of how to calculate annual income:

How is the applicant paid?	**How to calculate for annual**	**Example**
Weekly	Weekly gross amount X 52	$600.32 X 52 = $31,216.64
Bi-Weekly	Bi-weekly gross amount X 26	$1417.92 X 26 = $36,865.92
Semi-Monthly (Twice per month)	Semi-monthly gross amount X 24	$1325.28 X 24 = $31,806.72
Monthly	Monthly gross amount X 12	$1,288.52 X 12 = $15,462.24

If an applicant's weekly income fluctuates greatly (e.g., day labor), determine the total weekly income of each week worked by adding the gross income for each day the applicant worked in the week. Add the weekly totals together and then divide by the number of weeks worked to determine the average weekly gross amount. Once the average weekly gross amount is determined, use the weekly income calculation above to determine the annual income.

Year-to-date (YTD) information can be used if only one paycheck stub is available. For example, a June 30, 2021, pay stub reflects YTD $19,055, and the applicant is paid bi-weekly. Calculate the income by dividing the YTD income ($19,055) by the number of pay periods to date (13) to determine bi-weekly pay ($1,465.77) and then multiply by 26 pay periods to get an annual income of $38,110 ($19,055/13 = $1,465.77 x 26 = $38,110).

Individual Income for Imposition of Charges

Applicant's individual income is used for imposition of charges for program services, regardless of household size. For this purpose, an applicant's *individual* income may be greater than 400% of FPL if a multi-person household size was used to determine program eligibility. For more information on imposition of charges, please refer to the FDOH Patient Care Program Administrative Guidelines and guidance issued by the Health Resources and Services Administration.

Definition of Low Income for Florida State HOPWA Program

- Applicants seeking housing assistance from state HOPWA first must be determined core eligible under the eligibility rule. However, applicants who are not core eligible for HIV patient care programs based on the FPL limit should be assessed for a housing need and then referred to HOPWA to assess the applicant's eligibility for HOPWA assistance.
- HOPWA's program's income eligibility requirements allow applicants to be at or below 80 percent of their area's median income, which in some instances can be greater than 400 percent of FPL.
- Under these circumstances, if all other core eligibility requirements except FPL are met, applicants who might have a housing need should be given an NOE with a notation for **HOPWA only** and then referred to HOPWA for HOPWA income eligibility assessment.
- Applicants receiving an NOE exception for HOPWA services are not guaranteed to receive HOPWA

services; applicants must also meet HOPWA's eligibility requirements before they can receive any HOPWA services.

- Not all applicants who seek core eligibility will have a housing need.
- Not all applicants who are deemed eligible for core eligibility will qualify for HOPWA.

Insurance

Applicants must be screened for any health insurance or health care coverage (including Medicaid and Medicare) that would pay for any portion of services or medications paid for by the Ryan White Part B Program. If the pre-screening process determines the applicant is possibly eligible but does not have Medicaid services, the applicant must apply for Medicaid. The results page must be printed, the applicant's name and date of pre-screening written on the printout and the document scanned into the state-approved data system.

Please note: Medicaid screening must be completed at each eligibility verification unless an applicant currently has an active private insurance policy. Documentation must be scanned into the state-approved data system to ensure that the most current proof of screening is available.

Staff must vigorously pursue any potential health insurance coverage, including from the applicant's employer, family sponsored plans, government issued plans, COBRA and Federally Facilitated Marketplace options. Applicants who have access to health coverage and do not use it must be educated on the benefits of health insurance. All efforts should be documented in the applicant's chart. An applicant's failure to obtain or use current health insurance does not prohibit them from obtaining Ryan White eligibility but doing so ensures that Ryan White funds are used only after all other payers are exhausted.

Enrollment in VA services is not required to be eligible for patient care services funded by the HIV Section. However, VA services provide comprehensive health care coverage for veterans while the HIV Section only provides coverage for HIV-related services.

Payer of Last Resort

The Ryan White Part B Program must be the payer of last resort per federal legislation. Services must be billed to alternative payer sources prior to billing any portion of those services to the Ryan White Part B Program.

Employer-Sponsored Insurance

An employed applicant must show proof of employer sponsored insurance, such as a copy of their insurance card or proof of coverage letter. If unable to secure insurance through employment, applicants must show proof that insurance is not offered, such as a letter from their employer on company letterhead or a copy of their employer benefits handbook.

Applicants are required to take available job-based insurance that is deemed affordable. Plans that cost more than 9.61 percent of household gross income or do not meet the minimum value standards for affordability and coverage are not considered viable plans, according to HealthCare.gov.

A health plan meets the minimum value standard if it pays at least 60 percent of the total cost of medical services for a standard population and offers substantial coverage of hospital and doctor services.

Federally Facilitated Marketplace

An applicant who receives insurance through the Federally Facilitated Marketplace must provide proof of an active policy, such as a copy of an enrollment letter or a current premium payment notice.

Medicare (Parts A, B, C and D)

Applicants who have received SSDI for longer than 24 months or who are 65 years of age or older and who are not enrolled in Medicare Part A, B, C or D must submit proof of application for Medicare or a rationale for not applying. All efforts for enrolling applicants in Medicare should be documented in the applicant's chart. Reasons for not applying should be reviewed by supervisor.

SECTION 4: Notices of Eligibility and Ineligibility

Notice of Eligibility

The NOE is a document that indicates an applicant meets the eligibility requirements to receive allowable Ryan White services as stated in Chapter 64D-4, FAC. The NOE contains the applicant's name, address, household size and income.

The NOE should be:

- Completed no more than 30 days in advance of the applicant's most recent NOE expiration date
- Authorized for 366 days (date of submission plus 365 days)

Provide applicant with the original copy of the NOE and place a copy in applicant's file and/or into the state-approved database systems.

Notice of Ineligibility

An applicant may be deemed ineligible at any point during the eligibility process. A supervisory review is required for all cases determined ineligible before issuing the NOI.

The following documentation will be reviewed for accuracy to determine ineligibility:

- Completed eligibility application
- Required documentation

The NOI must be placed into the applicant's file and uploaded into the state-approved data system within two business days. A copy must be provided to the applicant. All efforts are to be made to assist the applicant in understanding the reason for the decision.

The following should be done when issuing an NOI:

- Advise applicant to contact the eligibility provider for a new eligibility determination should circumstances change.
- Refer applicant for possible assistance from other programs, including Ryan White Part C and/or Part D programs within the area, by providing the following information: name, address and phone number of referral.
- Advise applicant of their right to a fair hearing (see application Part 5, Rights and Responsibilities and Administrative Guidelines, for further guidance).

The applicant can choose to pursue the fair hearing instructions provided in the NOI; however, the eligibility office may not assist the individual with the appeal process other than providing possible referrals to legal aid or other legal counsel.

If the applicant chooses to appeal the decision, the agency where the applicant's eligibility was determined will be contacted by the local county health department or FDOH legal counsel, since the request for a fair hearing is submitted to the agency clerk in Tallahassee, Florida. Copies of the application and other documentation may be required. No further action is required by eligibility staff unless instructed by legal counsel. For additional information regarding applicant appeal, grievance or complaints, please refer to the Patient Care Program Administrative Guidelines.

Hearing Procedures

An administrative hearing may be conducted when an applicant requests to appeal the determination of eligibility. Hearing procedures are submitted in the form of requests, which are sent to and reviewed by the

agency clerk in Tallahassee, Florida. A hearing officer in Tallahassee will be assigned the case and the local FDOH attorney will represent the program. The agency clerk may request more information about the case before granting or denying the request. The local FDOH attorney will work closely with the program or eligibility staff for more information and clarification of the case as the appeal process progresses.

Closing the File

Collaborative efforts are encouraged to provide continuity of eligibility and care. All active eligibility files must remain open until an NOI is issued. Files may be closed for the following reasons:

- Applicant does not complete eligibility process.
- Applicant's income is greater than 400 percent of FPL.
- Applicant is unable to provide proof of presence of HIV.
- Applicant does not live nor intend to live in Florida.
- Applicant has insurance or payer that meets service needs being requested.

The file is closed when all documentation is assembled, and the determination is completed. All file closures must be approved and signed by a supervisor. All efforts for determining applicant eligible for services should be documented in the applicant's chart. All closed files must follow the record retention policy.

APPENDIX—Resources and Linkages

The primary tasks of eligibility staff after a determination of eligibility include referrals and/or linkages to the following:

- A choice of case management service providers in the area (if applicable). If the employee completing the eligibility process is employed by a case management agency, the client should still be provided a choice of case management agencies in the service area.
- ADAP services.
- HOPWA services.
- Allowable services based on availability, accessibility and funding of the service in the client's local area. Referrals may be made directly to the HIV patient care programs, when indicated.

Notate client's eligibility chart indicating where client has been referred and/or linked for services in the state-approved database system.

AIDS Drug Assistance Program
ADAP offers medications and insurance assistance to uninsured, underinsured and insured clients. Eligible insured ADAP clients may receive assistance with premium and/or copay and deductible costs. Insured ADAP clients have private or government-sponsored health insurance coverage that includes prescription drug coverage equivalent to the ADAP formulary drugs.

To be referred to ADAP, a client must:

- Be determined eligible for HIV patient care programs.
- Meet ADAP qualifications.

Refer to the ADAP guidelines for further guidance. Clients should be referred to ADAP for program qualification determination.

Children's Medical Services Network
Children's Medical Services (CMS) is a collection of special programs for eligible children with special needs. Medical care is provided at community doctors' offices and hospitals, local specialty medical clinics and university medical centers. CMS offers managed care services for people who have special health care needs that require extensive preventive and ongoing care and meet one of the following:

- Are under the age of 21 and eligible for Medicaid.
- Are under the age of 19 and eligible for Florida KidCare.

Visit cms-kids.com for more information.

Clinical Trials
Clinical trials are research studies that follow predefined protocols. Guidelines for all clinical trials can be researched at clinicaltrials.gov.

Copays and Deductibles
Ryan White Part B Health Insurance Premiums/Cost Sharing line-item funding can cover copays and deductibles for allowable services and medications. Health insurance not covered by ADAP is also covered.

Employer-Sponsored Health Insurance
Employer-sponsored health insurance is a health policy selected and purchased by an employer and offered to eligible employees and their dependents.

Federally Facilitated Marketplace

The Federally Facilitated Marketplace is a group of organizations that facilitate structured and competitive markets for purchasing health coverage. The federal government created the marketplace so that citizens who do not have coverage through a job, Medicare, Medicaid, CHIP or another source can find and enroll in plans that fit their budget and coverage needs.

Florida KidCare

Florida KidCare is the state's health insurance program for uninsured children from birth to age 18 and includes 4 different parts/programs (MediKids, Florida Healthy Kids, CMS Health Plan and Medicaid). When an individual applies, Florida KidCare will identify which program a child may be eligible for based on age and family income. Some of the services Florida KidCare covers are:

- Doctor visits, check-ups, immunizations, hospital stays and surgery
- Prescriptions
- Emergencies
- Vision, hearing, dental and mental health

Visit floridakidcare.org for more information.

Local Assistance Programs

Areas may have additional locally-funded assistance programs to which applicants should be referred. If a client is eligible for or participating in locally-funded assistance programs, documentation verifying the client's eligibility for these programs must be scanned into the state-approved data systems.

Medicaid

Medicaid is a state and federally funded entitlement program where the Florida Department of Children and Families (DCF) and/or the Social Security Administration (SSA) determine Medicaid recipient eligibility. Clients who are Medicaid eligible will not be eligible for HIV patient care services/benefits where the same service is covered by Medicaid.

Eligibility staff must have access to FLMMIS or other Medicaid software to verify current Medicaid enrollment. Individuals denied Medicaid due to withholding information may be deemed ineligible for Ryan White Part B services. Contact the HIV Section for review for possible exception. Additional information on Medicaid can be found at myflorida.com/accessflorida. Individuals who might be eligible for Medicaid include:

- Parents and caretaker relatives of children
- Children
- Pregnant women
- Individuals formerly in foster care
- Non-citizens with medical emergencies
- Aged or disabled individuals not currently receiving SSI

All individuals potentially eligible for Medicaid benefits and not currently accessing some form of insurance must be pre-screened for Medicaid eligibility by doing the following:

1. Visit myflorida.com/accessflorida.
2. Under "Access Your Benefits," click "Am I Eligible?"
3. On the ACCESS Florida page, under "Get Started Now," click the "Am I Eligible?" link.
4. Click the "Next" button to move through and answer each page of questions.
5. Verify the information and click "Next" to submit.

Medically Needy (Share-of-Cost Medicaid)

Individuals who are not eligible for full Medicaid because their income or assets are over the Medicaid program limits may qualify for the Medically Needy program. Individuals enrolled in Medically Needy must have a certain amount of medical bills each month before Medicaid can be approved. This is referred to as a "share of cost" and varies depending on the household's size and income.

Once an individual meets the share of cost for the month, the individual must contact DCF to complete bill tracking and approve Medicaid for the remainder of the month.

Medicare

Medicare is health insurance for people aged 65 or older, under age 65 with certain disabilities or at any age with end-stage renal disease. Medicare is a federally funded entitlement program administered by the Centers for Medicare and Medicaid Services. Persons with disabilities are eligible for Medicare after two years of being determined disabled by the SSA. Individuals who are eligible for Medicare are encouraged to enroll in all coverage that is available before accessing Ryan White Part B services.

Most people receive Medicare health coverage in the following ways:

- Medicare Part A (hospital insurance)—Part A covers inpatient hospital stays, care in a skilled nursing facility, hospice care and some home health care.
- Medicare Part B (medical insurance)—Part B covers certain doctors' services, outpatient care, medical supplies and preventive services.
- Medicare Part D (prescription drug coverage)—Part D helps cover the cost of prescription drugs (including many recommended shots or vaccines).

Medicare Part D

Medicare Part A and B recipients are required to enroll in a drug plan under Part D. There are two ways to get Medicare Part D prescription drug coverage:

- Join a Medicare Part D prescription drug plan that adds drug coverage to the original Medicare plan.
- Join a Medicare plan (like an HMO) that includes prescription drug coverage as part of the plan.

Medicare recipients who are below 152 percent of FPL are also required to be enrolled in the low-income subsidy (also called "Extra Help") where monthly premium costs vary depending on the plan selected.

Additional information can be found at medicare.gov.

Patient Assistance Program

A patient assistance program (PAP) provides for electronic claim adjudication and electronic payment of client cost-sharing, such as copays and deductibles for prescription drug coverage available through an insurance plan. PAPs are available through pharmaceutical companies to provide access to free or discounted medications to people with limited income. Qualification guidelines vary among pharmaceutical companies.

Further information can be found at needymeds.org or rxassist.org.

U.S. Department of Veterans Affairs

The VA is a federal agency created to assist former members of the of the U.S. military and their dependents in preparing claims for and securing compensation, hospitalization and other medical benefits for eligible persons. Veterans will be issued documentation of VA eligibility or denial.

Enrollment in VA services is not required to be eligible for patient care services funded by FDOH.

For more information on VA services, please visit va.gov/health.