



Charlie Crist
Governor

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Secretary

INTEROFFICE MEMORANDUM

DATE: May 30, 2007

TO: County Health Department HIV/AIDS Program Coordinators
County Health Department HIV/AIDS Contract Managers
County Health Department AIDS Drug Assistant Program Staff

FROM: Joseph P. May
Program Administrator, Patient Care

SUBJECT: Eligibility Question/Answer Document

FOR INFORMATION ONLY

The initial statewide *Determining Eligibility Training* was held (January–March) for HIV/AIDS Patient Care Program staff, eligibility staff, supervisors, HIV/AIDS program coordinators, contract managers and lead agency personnel. The regional training sites included the following: Tallahassee 1/9 Ft. Walton 1/17; Jacksonville 2/7; Gainesville 2/9; Brevard 2/19; Orlando 2/19; Tampa 1/23 and 2/20; and West Palm Beach 2/26; Sarasota 3/6; Ft. Lauderdale 3/8 and 3/13; and Miami 3/13 and 3/14. Approximately 450 eligibility training Certificates of Attendance have been issued. The second phase of eligibility training began May 4, 2007 to provide additional clarification of the *Determining Eligibility Staff Procedures Manual*.

Please find attached an eligibility question/answer document which includes eligibility questions raised during and after the training sessions. The responses are intended to provide clarification and must be used in conjunction with the *Determining Eligibility Staff Procedures Manual*. Please distribute this document or make it accessible to all eligibility staff in your area. This document will be posted on the eligibility website within the next week. Thank You.

JM/pm
Attachment
cc: Tom Liberti, Bureau Chief
Sherry Riley, Program Administrator, Operations and Management

Department of Health
Division of Disease Control, Bureau of HIV/AIDS
HIV/AIDS Patient Care Programs
Eligibility Determination

ELIGIBILITY QUESTIONS/ANSWERS

On January 3, 2007, the Department of Health, Division of Disease Control, Bureau of HIV/AIDS, Patient Care Resources Section filed the “eligibility rule” for final adoption with the Department of State, Bureau of Administrative Code. The new rule Chapter 64D-4, Eligibility Requirements for HIV/AIDS Patient Care Programs, Florida Administrative Code became effective January 23, 2007.

The eligibility rule provides the standardized eligibility requirements, documentation and procedures for all of the HIV/AIDS Patient Care Programs which include: Ryan White Title II Consortia Program, Ryan White Title II AIDS Drug Assistance Program (ADAP), Ryan White Title II AIDS Insurance Continuation Program (AICP), State Housing Opportunities for Persons with AIDS Program (HOPWA), and HIV/AIDS Patient Care Programs provided by the Patient Care Networks and County Health Departments, as administered by the Department of Health, Bureau of HIV/AIDS.

The initial statewide *Determining Eligibility Training* was held (January – March, 2007) for HIV/AIDS Patient Care Program staff, eligibility staff, supervisors, HAPCs, contract managers and lead agency personnel at the following regional locations: Tallahassee 1/9. Ft. Walton 1/17; Jacksonville 2/7; Gainesville 2/9; Brevard 2/19; Orlando 2/19; Tampa 1/23 and 2/20; and West Palm Beach 2/26; Sarasota 3/6; Ft. Lauderdale 3/8 and 3/13; and Miami 3/13 and 3/14. Approximately 450 Eligibility Training Certificates of Attendance have been issued.

This document includes eligibility questions raised during and after the training sessions, and is intended to provide clarification to the procedures established in the *Determining Procedures Eligibility Staff Procedures Manual*, January 2007.

**THIS DOCUMENT MUST BE USED IN CONJUNCTION WITH THE
DETERMINING PROCEDURES ELIGIBILITY STAFF PROCEDURES MANUAL.**

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| • Eligibility Infrastructure and Coordination | Questions: #1-7 |
| • Transferring, Closing and Maintaining Eligibility Files | Questions: #8-11 |
| • Notice of Eligibility | Questions: #12-15 |
| • Chapter 7: Medicaid And Other Program Screening | Questions: #16-17 |
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May 15, 2007

Eligibility Infrastructure and Coordination

1. What are the procedures if an Area (1-15) wants to change its existing eligibility infrastructure?

The eligibility infrastructure within an area has not been standardized statewide and can remain the same or change to better suit the areas needs. Centralization of eligibility has occurred in some areas. However, changing the existing eligibility infrastructure is a local decision and would include the coordination and input from all affected parties. There are contract, funding, possible service disruption to applicants/clients and other considerations which must be assessed by local department staff and providers before changing an existing eligibility structure.

2. If a client becomes ineligible before or at the time of the re-determination, how will the other programs who have enrolled the client be advised?

In the absence of a data system to coordinate this information, the ADAP, AICP, HOPWA and Case Management programs, within the same eligibility jurisdiction and serving potentially the same clients must coordinate with each other. It is suggested:

- Each area should have an updated list of designated eligibility offices and all of the programs (ADAP, HOPWA, AICP and Case Management Agencies), with the names, addresses and phone numbers, for use to advise each program when an existing client becomes ineligible.
- On a routine basis, all of the programs should review the client's Notice of Eligibility for valid dates of eligibility.
- At the time of a closure or transfer, the originating office is responsible for advising the other programs accessed by the client that the eligibility status has changed to ineligibility.
- Eligibility staff could contact ADAP, state HOPWA or AICP immediately, if there is a change in the eligibility status of a client.

Additional information is contained in Question #8.

3. Can the originating eligibility office responsible for maintaining the client's eligibility file, transfer the eligibility responsibility to one of the other HIV/AIDS Patient Care Programs?

Not unless the location or other factors relating to the originating eligibility office is a "barrier to care" for the client. Please refer to Question #8 for more information about eligibility files.

4. How are the eligibility applications, manuals and disks ordered?

Applications

The official Application to Receive Allowable Services for HIV/AIDS Patient Care Programs (DH 150-884, effective 1/07) in English, Spanish or Creole are ordered by local Department of Health staff through the Warehouse Distribution Center in Tallahassee. The warehouse has been stocked with a large supply of application/brochures and the county health departments can order in packages of 100 at \$2.19 per package of 100 as follows:

- (1) Complete a Supply Requisition Management System, Supply Requisition Form (DH 1370H) using the following codes:
 - The Organizational and Sub Codes are the established CHD #.

- The DOH Stock Numbers for the Applications are:
English - 5730-884-0150-1
Spanish -5730-940-0150-1
Creole – 5730-941-0150-5
 - Quantity is no more than 5 at a time; less for Spanish and Creole
 - Unit of Issue is 100/pck.
 - Description is Eligibility Application DH 150-884(English, Spanish or Creole)
 - The cost to the CHD is \$2.19 per package. Non-DOH providers cannot order directly yet, so please distribute as needed.
 - Complete the rest of the form as asked.
- (2) Fax the completed form to (850) 414-7753.
- (3) The Supply Requisition Form (DH1370H) can be located on the Intranet as follows, but the CHD may have a supply of them available: Go to Home page of Florida Intranet then click Administration/General Services/ Support Services (find the-Distribution and Disposition Center and click/Other Links (click-DOH Electric Warehouse)/S-T/ Supply Requisition) – Print Out.

The warehouse staff are very helpful and can be contacted directly at 850 414-7048 if there are difficulties with ordering the applications. The coordination between the lead agencies and the county health departments are necessary since ordering is limited to county health departments, at this time.

Eligibility Manuals and Disks

The eligibility manuals and disks (with the forms) are ordered by local Department of Health staff through their contact at the Bureau of HIV/AIDS, Patient Care Section in Tallahassee. There should be only a 1-2 day turnaround if the name of the agency, physical address, the phone number, a contact person and the number of manuals and disks requested are stated either by e-mail or phone.

Eligibility Training

The second and more intense round of eligibility training began May 4, 2007 in Tallahassee. The Division of Disease Control, Bureau of HIV/AIDS will be scheduling additional regional eligibility trainings based on the demand. The times and locations will be posted on the Patient Care Eligibility Website:

http://www.doh.state.fl.us/disease_ctrl/aids/care/EligibilityAdRule.html

Eligibility Certificates

Eligibility Certificates of Attendance are issued at the time of the training, if the names of the participants have been provided a week before the scheduled training. Otherwise, they will be mailed.

5. Do county health departments that receive GR funds (Schedule C) for HIV Patient Care Programs have to determine eligibility for all of their clients as per the rule?

Yes. These procedures have not changed. The HIV/AIDS Patient Care Programs funded through General Revenue and Patient Care Network funds fall under the jurisdiction of Chapter 64D-4 F.A.C. There are currently 33 County Health Departments which receive the GR funds and 7 Patient Care Network geographic areas.

6. (a) Can agencies charge (bill) for case management services if the only service provided the client is eligibility determination? (b) Can requirements such as the Assessment Process and Service Plan be waived when only eligibility determination is needed?

- (a) Charging (billing) for case management services is a funding and contract issue. Eligibility has always been funded under case management, and there have been no changes to that funding method.

- (b) There have always been provisions for serving clients who do not want or need case management. Please refer to the following sections in the Case Management Standards and Guidelines:

Section 1-1 (last sentence) page 1-1 Not all clients need to be case managed, and clients who are capable and willing to case manage themselves should be encouraged to do so.

Section 1-6 page 1-3 and 1-4: Case management agencies should consider staff other than case managers to be trained to complete the eligibility determination process allowing case managers more time for direct client involvement.

Section 4: page 4-1 and 4-4: The case manager will not be required to conduct a needs assessment or plan of care if the primary case manager for the client remains with PAC or another agency.

Now that eligibility determination is established and defined in an administrative rule, there is nothing to preclude an area from considering other infrastructure options for eligibility, case management and administrative management for clients who do not want or need case management, but need a method to access services. (The Bureau of HIV/AIDS, Patient care staff are in process of reviewing the issues associated with clients who do not need or want case management.)

7. What if one HIV/AIDS Patient Care Program questions the documentation or procedures used to determine a client's eligibility from another HIV/AIDS Patient Care Program?

If there are questions about the accuracy of an ADAP, AICP, Case Management or HOPWA program's determination of eligibility or ineligibility for a specific client, the issue should be referred immediately to the supervisor and/or local department staff for resolution. A review of the file and circumstances may be required to verify client eligibility and/or to clarify that the existing procedures are understood and practiced. Refer to Chapter 12, page 77 "*Eligibility or Program Qualification Disputes.*"

However, if the Notice of Eligibility has already been issued, it must be accepted as verification the client meets all of the eligibility requirements. The issue in question is then reviewed through coordination with the originating eligibility office and the program questioning the eligibility status. If it is determined the correct documentation was not obtained, or an error has occurred and the client is ineligible, then the procedures for determining ineligibility are followed. If there was not an error, the client will continue to receive services without interruption. Refer to Chapter 10: *Determination of Ineligibility*, pages 67-69.

The same procedures are followed, if there is a programmatic question from ADAP, AICP, Case Management or HOPWA about a decision to enroll or not enroll a client.

TRANSFERRING, CLOSING AND MAINTAINING ELIGIBILITY FILES

8. There is little information in the manual about transferring and/or closing an eligibility file. What are the procedures?

Prior to the standardization of the eligibility requirements and procedures, Case Management, ADAP, HOPWA or AICP files were transferred or closed based on their respective manual guidelines, and the eligibility documentation was included in the file.

However, now that there are standardized eligibility procedures for all programs, the eligibility and programmatic files (which were one of the same) have been separated. The procedures to close, transfer and retain the programmatic files for AICP, state HOPWA and ADAP are located in their respective manuals. The procedures for closing, transferring and retaining eligibility files include the following and should be incorporated with the eligibility manual for future reference:

- (a) Client Transfers Outside The Eligibility Jurisdiction, But Within The State.
- (b) Client Moves Out Of State.
- (c) Client's File is Closed.
- (d) Client Transfers to Another Eligibility Office Within the Eligibility Jurisdiction.

(a) Client Transfers Outside The Eligibility Jurisdiction, But Within The State

When a client transfers outside the originating eligibility jurisdiction, but within Florida and requests the eligibility file be transferred, contact with the receiving agency may be necessary to obtain or provide more client information relating to the transfer. Confidentiality protocol is followed. In addition:

- The originating office officially closes the client's eligibility file and includes the appropriate documentation explaining the reason for transferring and closing the eligibility file.
- The originating eligibility office contacts the other programs accessed by the client to update them on the client's transfer out of the eligibility jurisdiction.
- The receiving office revises the Notice of Eligibility to include the new eligibility location, and the name of the eligibility staff and disseminates the information to the other programs accessed by the client. The established 6-month eligibility date remains unchanged.
- The originating eligibility office will close their eligibility file on the specific client, and retain the original information according to the Department of Health's retention schedule (5 years administrative; 7 years for medical).

(b) Client Moves Out Of State

When a client moves out of state and requests the eligibility file be transferred, contact with the receiving agency may be necessary to obtain or provide more client information relating to the transfer. Confidentiality protocol is followed. In addition:

- The originating eligibility office copies the entire file and sends it to the receiving agency.
- The originating eligibility office officially closes the client's eligibility file and includes appropriate documentation explaining the reason for transferring and closing the eligibility file.
- The Notice of Eligibility may or may not be valid in the new state.
- The originating eligibility office will retain the original eligibility file according to the Department of Health's retention schedule (5 years non-medical; 7 years for medical).

(c) Client's File is Closed

A client's file is closed for many reasons, such as:

- The client is deceased;
 - The client has requested closure;
 - The client has transferred to another eligibility jurisdiction within the state;
 - The client has been incarcerated in a State or Federal prison;
 - The client has been enrolled in Medicaid (PAC; MediPass; Medicaid; HMO);*
 - The client has not recertified the eligibility status.
 - The applicant or client was determined ineligible.
- * Not all Medicaid files for clients enrolled in Medicaid will be closed if accessing HIV/AIDS Patient Care Program services.

When a client's file is closed, the following procedures are followed:

- The originating eligibility office closes the client's eligibility file and includes appropriate documentation, explaining the reason for closing the file.
- The originating eligibility office immediately advises the other programs (AICP, ADAP, HOPWA or Case Management) of the client's status, especially, if there is a determination of ineligibility.

- The originating eligibility office will retain the original eligibility file according to the Department of Health's retention schedule (5 years non-medical; 7 years for medical).

(d) Client Transfers to Another Eligibility Office, Within the Eligibility Jurisdiction

A client should not be transferring to another eligibility office within the same eligibility jurisdiction as a matter of routine. The current procedures require the originating eligibility office to maintain a client's eligibility responsibility to ensure the client and the programs accessed by the client, know who has determined the eligibility, and other important eligibility information. More specifically:

- The name of the originating eligibility office and the location of the client's original file needs a permanent home known by the client, other programs accessed by the clients, and for auditors who may need a specific document obtained during the eligibility process. (Refer to Question #9)
- The client's re-determination date and the location is established on the client's Notice of Eligibility.
- A client's enrollment status may change from unqualified to qualified (from ADAP, AICP and HOPWA), but the location and whereabouts of the eligibility file needs to remain constant to eliminate client and program confusion about eligibility responsibilities.

However, there is an exception to transferring a file within the eligibility jurisdiction, but only if the location of the originating eligibility office becomes a "barrier to care" for the client. For instance, (1) A client in a large geographical eligibility jurisdiction (like Areas 3/13 or 2A) moves and relocates a considerable distance from the originating eligibility office creating transportation problems for the client, or (2) A client has unresolved issues with the originating eligibility office, and all efforts to resolve these issues have been unsuccessful.

Under circumstances such as these, a transfer within an eligibility jurisdiction can be considered, following the established procedures:

- Another eligibility office (ADAP, AICP, Case Management, HOPWA) within the same jurisdiction must agree to accept the transfer.
- The originating office copies the entire file and sends it to the receiving eligibility office.
- The receiving office revises the Notice of Eligibility to include the new eligibility location, and the name of the eligibility staff, and disseminates the information to the other programs accessed by the client. The established 6-month eligibility date remains unchanged.
- The originating eligibility office will close their eligibility file on the specific client, and retain the original information according to the Department of Health's retention schedule (5 years administrative; 7 years for medical).

Please Note: The above procedure should be utilized only as an exception. An originating eligibility office which no longer wants to serve a client who does not qualify for their specific program would not constitute a "barrier to care" for a client. Please refer to Chapter 6, pages 27-28 of the eligibility manual for information about what is required in the applicant's eligibility file and Chapter 9, pages 63-65 for *Notice of Eligibility and Closed Files* information.

9. What if an auditor wants a copy of something in the eligibility file, and another program/agency determined the eligibility and is maintaining the file?

The originating eligibility office is responsible for obtaining and transferring the requested information to a requesting program, but it should not be a routine request. The HIV/AIDS Patient Care Section will be working with auditors (prior to audits) to advise them of the standardization of the HIV/AIDS Patient Care Programs eligibility requirements and procedures under Chapter 64D-4 F.A.C. For purposes of verifying eligibility, the Notice of Eligibility is all that is required for inclusion in ADAP, AICP or State HOPWA files.

10. Which program would be held accountable if specific eligibility documentation is missing - the program being audited or the originating eligibility office?

The originating eligibility office is held accountable if the eligibility documentation is not maintained. This is why it is very important that the originating eligibility office ensure all documentation is included in the client file (Application, Eligibility Assessment Worksheet, Proof of HIV, income documentation, etc.). The eligibility manual references the required documentation and file maintenance in numerous sections.

11. New applicants must complete an application (DL 150-884), but what about existing clients?

A new application is also completed for each existing client during the re-determination of eligibility. The client's rights and responsibilities (Part 6) on the application should be reviewed with the client and the appropriate initials and signature obtained, the same as for a new client.

The original application is filed for future reference. The DL 150-884 is incorporated by reference into the eligibility rule and is the only application which can be used for purposes of eligibility for the HIV/AIDS Patient Care Programs.

NOTICE OF ELIGIBILITY

12 (a) If a client presents at ADAP, AICP, HOPWA or Case Management with the required Notice of Eligibility, should copies of the client's eligibility documents be obtained from the originating eligibility office? (b) Does Title I have to accept the Notice of Eligibility as verification?

(a) No. The Notice of Eligibility provides verification the client meets all of the eligibility and documentation requirements for HIV/AIDS Patient Care Programs. The originating office is responsible for maintaining the eligibility file. Chapter 64D-4 F.A.C. standardized the eligibility requirements and procedures to eliminate the client and staff from having to complete and duplicate the eligibility process. (Refer to Chapter 9, pages 63-64, *Uses of the Notice and Referrals*).

(b) No. Title I and other local indigent programs do not fall under the jurisdiction of the eligibility rule, but it would be beneficial to all programs and clients, if the department's Notice of Eligibility was accepted as verification of the eligibility requirements.

13. What if one of the HIV/AIDS Patient Care Programs will not accept the Notice of Eligibility from another HIV/AIDS Patient Care Programs as verification of the eligibility requirements?

Please refer to Questions #12(a). Supervisors should be consulted if further clarification is required for a specific agency or program. Refer to the eligibility manual *Introduction* and Chapter 9, *Determination of Eligibility*, pages 63-64, *Uses of the Notice and Referrals*; and the Eligibility Rule, *Attachment A*.

14. What if a client loses their original Notice of Eligibility?

The originating office should prepare another original Notice of Eligibility for the client using the same information as presented on the original. The date the original was lost is documented on the new Notice and a copy is maintained in the eligibility file.

15. Does the Notice of Eligibility ensure ADAP, AICP or state HOPWA enrollment into their programs?

No. Eligibility is a pre-requisite for enrollment into these programs and the Notice of Eligibility will provide verification of eligibility; but it does not guarantee enrollment into the single service programs.

The programmatic qualifications or requirements are contained in the respective ADAP, HOPWA or AICP manuals or guidelines. Only ADAP, HOPWA or AICP staff can enroll a client into one of the respective programs. *Eligibility* refers to the eligibility requirements established in the administrative rule, and *enrollment* refers to programmatic qualifications for ADAP, HOPWA or AICP.

Refer to the following references for more information about *Program Qualifications*: Chapter 1 page 5, *Allowable Services and page 7 (15) Program Qualification Definition*; Chapter 12, Pages 75-77, *Program Qualification*, and scattered references throughout the manual.

CHAPTER 7: MEDICAID AND OTHER PROGRAM SCREENING

(Refer to Pages 37-41)

16. Is a denial letter from Medicaid required in order to complete an applicant's eligibility determination?

Payer of last resort is an integral part of eligibility determination, and all efforts should be made to ensure the HIV/AIDS Patient Care Programs' services are the payer of last resort. Denial letters provide appropriate and good documentation that the applicant has applied, and is not eligible for a specific program, such as Medicaid. Many applicants will have denial letters to submit, however, it is important to recognize that at the time of eligibility:

- Not all applicants will have applied for Medicaid.
- Not all applicants will need to apply for purposes of eligibility.
- Not all applicants who have applied and were denied will have their denial letters.
- Not all applicants will be able to obtain the denial documentation, during the eligibility time frame.

Medicaid can take up to 2-3 months to process a new application or to replace a denial letter if lost. In addition, although an applicant may appear to be eligible, until Medicaid makes the determination it cannot be assumed.

The Procedures: If an applicant meets all of the eligibility requirements, but screening for Medicaid is incomplete due to the lack of a denial letter for numerous reasons, a Notice of Eligibility can be issued for a designated time period (2-4 months) to allow the applicant access to our services, pending a Medicaid eligibility determination. The eligibility status is monitored for the appropriate documentation, and if not obtained as requested, a determination of ineligibility can be pursued in accordance with Chapter 7, page 57 and Chapter 10, page 67. This procedure applies to:

- an applicant who has not applied for Medicaid at the time of eligibility, but there is a high probability the applicant will be Medicaid eligible.
- an applicant who has applied for Medicaid and states he/she was denied Medicaid eligibility, but cannot produce the eligibility letter.

Other Factors:

- An applicant who has not applied for Medicaid, and is obviously not eligible for Medicaid should not be asked to apply for Medicaid. The circumstances are noted in the file and a Notice of Eligibility is issued, if all other eligibility requirements are met.
- A Medicaid client can be determined eligible to receive "allowable services" from the HIV/AIDS Patient Care Program ,provided the services are not offered by Medicaid.

17. If an applicant is eligible for services from the Veteran's Administration (VA) is he/she ineligible to receive HIV/AIDS Patient Care services?.

No. Although the HIV/AIDS Patient Care Programs are a payer of last resort applicants are not required (by federal policy) to participate in the VA program if they prefer HIV/AIDS Patient Care services. However, this does not preclude eligibility staff screening for VA and encouraging participation in VA if services are available and accessible.

INSURANCE (Refer to Pages 41-42)

18. When should an applicant be asked to produce a statement from an employer to verify that health insurance is not available?

This response is very similar to the Medicaid Question #16.

Payer of last resort is an integral part of the eligibility determination and all efforts should be made to ensure the HIV/AIDS Patient Care Programs' services are the payer of last resort. This includes an applicant's access to insurance. The applicant's employer-sponsored insurance benefit or the policy itself provides good documentation that the applicant is or is not covered adequately by health insurance. However, it is important to recognize that at the time of eligibility:

- Not all applicants will be employed.
- Not all applicants will have employer-sponsored health insurance.
- Not all applicants who have access to employer sponsored health insurance will have applied.
- Not all applicants employer sponsored health insurance will be adequately covered.

Depending on the employer and the employer-sponsored benefit, there may be a "window" for open enrollment for health insurance or a policy may not provide adequate coverage (refer to page 42, *Insurance Policies*). Due to the various circumstances associated with insurance screening, the following procedures are established specifically for this eligibility requirement.

The Procedures: If an applicant meets all of the eligibility requirements, but screening for health insurance is incomplete due to the inappropriate documentation within the eligibility time period for numerous reasons, a Notice of Eligibility can be issued for a designated time period (1-5 months) to allow the applicant access to our services while the determination of adequate or accessible health insurance is determined. The eligibility status is monitored for the appropriate documentation and if not obtained as requested, a determination of ineligibility can be pursued in accordance with Chapter 10, page 67. These procedures apply to:

- An applicant who has missed the window of open enrollment from his employer-sponsored health insurance.
- An applicant who has a health insurance policy which is under review (by AICP).
- An applicant needs time to obtain a statement from his employer, but needs treatment or services.

Other factors:

- If the applicant works for a company or small business, he/she can be asked to provide a copy of the benefits handbook from the company, or a statement on company letterhead stating what benefits are or are not available. The statement on company letterhead may be addressed "To Whom It May Concern" in order to prevent the applicant from having to tell the employer anything that may identify him/her as an HIV/AIDS applicant.
- If the eligibility staff is familiar with the client's employer and knows insurance is not available, the applicant's declaration that insurance is not available is documented on the eligibility worksheet.

Chapter 7: Income and Cash Assets

(Refer to Pages 43-56).

19. The 2007 Federal Poverty Level has just been released from HRSA. Which FPL do we use?

Chapter 64D-4.002 (10) F.A.C. establishes the Federal Poverty Level effective February 2006 as the required FPL version for purposes of determining eligibility for the HIV/AIDS Patient Care Programs (*Attachment A*). The charts in the *Determining Eligibility Procedure's Manual* are the correct charts eligibility staff should be using and continue to use until a rule amendment is completed. Refer Attachments A and L and Step 2. Calculating the Federal Poverty Level, Pages 50-51.

20. (a) What if the monthly and annual income calculated from the FPL are different? Which should be used? (b) How do you calculate or annualize an applicant's salary which fluctuates?

The 5 steps to determining an applicant's income (pages 46-56) must be reviewed carefully with the following information as further clarification:

(a) There is a slight difference between the annual and monthly charts (*Attachment L*). For example:

Annual Chart: Income for 1 is \$29,400

Monthly Chart: Income for 1 is \$2451 (Monthly) x 12 months (when projecting a salary) = \$29,412 (A Difference of \$12 Annually)

The Monthly Income Chart is used to project the annual income of an applicant who is paid regularly. For example, an applicant who is paid monthly (or bi-weekly) and presents 3 months of pay stubs).

The Annual Chart is used after the monthly income has been annualized.

When there is a conflict between the two charts, the chart which favors the applicants income amount under 300% is used. There will be a minor difference.

(b) An applicant's salary can only be annualized by what is known. An applicant's salary cannot be annualized by what is unknown. Examples include the following:

- A seasonal worker who does not have a consistent weekly or monthly income is assessed by the pay stubs submitted for a 90-day (3 month) period. Use what is provided to determine the projected amount. If the applicant is over 300% (based on the household size), the applicant is advised to reapply when his/her circumstances change.
- A construction worker who has made \$3000 a month for the past 3 months, but states his salary will drop to \$400 a month will be assessed by what was provided for the 90 day (3 month period), and not the anticipated amount. This figure, \$3000 a month is projected over a 12 month period. If the applicant is over 300% (based on the household size), the applicant is advised to reapply when his/her circumstances change.

All of the income documentation references in Step 4. Determining the Household income should be reviewed and applied as appropriate depending on an applicants circumstances. An applicant's

unemployment status or new employment status is always a factor when determining an applicant's income.

A Notice of Eligibility *Pending Employment* or due to other circumstances can be issued for a limited time period similar to the procedures for Medicaid (Question # 16) and Insurance (#18). The applicant's employment or income circumstances should be monitored. Refer to *Types of Income Documentation* pages 53-54, and *Divestiture/Transfer Assets*, page 55.

21. What if an applicant has a joint mortgage with another adult, but they have separate finances – is this commingled funds and would this be a household of 1 or 2?

Commingled funds are *financial arrangements to the extent that the banking, savings, business, mortgage agreement and other personal finances are indistinguishable (Counted, page 47)*. Joint names on a mortgage alone would not be considered commingled funds. It may be a red flag that more information is needed, but if all other finances and assets are separated commingling would not apply. Refer to Step 2, Page 47, *Counted* and Page 48 *Commingled Funds*.

Therefore, in this example the household size would be considered 1 and the adult's salary and cash assets would not be included in the financial determination. However, if the adult provided some type of income to the applicant it would be counted as income. Refer to *Household Income*, page 52-55

22. When is a Domestic Partners status used?

For purposes of eligibility, the information about Domestic Partners is provided for technical assistance purposes only when determining household size. The term has no other significance to the eligibility process and verification of a Domestic Partner status is not required. Refer to *Determining Household Size*, page 47.

23. To get the blue book value of vehicles, can NADA used cars.com be used?

Most of our clients are under 150% of the FPL and will not meet the \$12,000 cash asset requirement. Please remember that the personal car (per adult counted in the household size) of an applicant are not considered as assets during the eligibility process. A second car or home would be considered an asset. If it is necessary to verify cash assets of a car, the Kelly Blue Book and NADA for vehicles are acceptable. Refer to Step 5. *Assets and Items of Value*, Page 56.

24. What documents are acceptable for persons self – employed, not a US citizen & someone who does not file income taxes with IRS or is paid in cash under the table?

There are many types of documentation for income found in Step 4. *Household Income*, pages 52-55. It may be necessary to accept a statement as to how the applicant receives food, clothing and shelter with an explanation about the consequences of failure to be truthful as contained in Part 6. Rights and Responsibilities.

25. Is there a Patient Care website with eligibility information?

Yes. It is located in the Bureau of HIV/AIDS Website/Patient Care/ Eligibility Information For HIV/AIDS Patient Care Programs.

http://www.doh.state.fl.us/Disease_ctrl/aids/care/EligibilityAdRule.html.