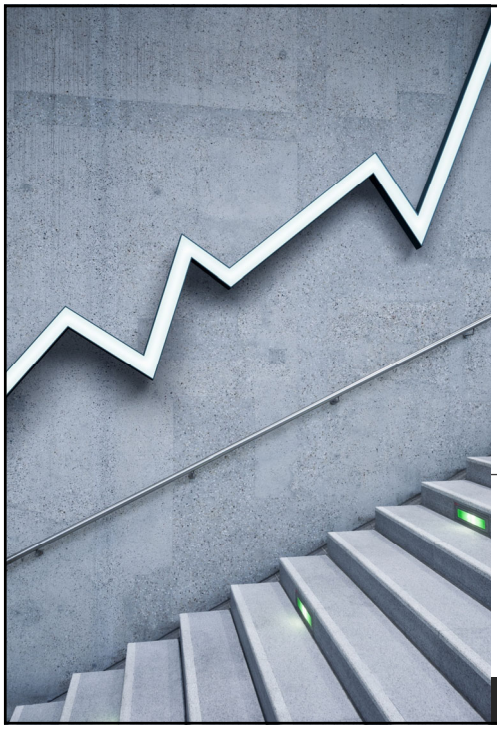

Program Eligibility Updates

APRIL 2023

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
IDPH
PROTECTING HEALTH, IMPROVING LIVES

1

1

Housekeeping

- This training is being recorded and will be posted so please be careful on disclosures or providing personal information.
- Access to handouts – Chat box
- Methods to ask questions
  - Type in the chat box
  - Raise hands
- Let me know if moving to quickly
- Recordings will be on the website

2

2

MOMENT OF SILENCE

We will now observe a moment of silence for those that have came before us, all those who have fought the good fight and for all those who are still fighting.

3

3

WHY MAKE CHANGES?

1. On October 19, 2021, HRSA issued a policy clarification notice (PCN 21-02) that changed the federal rules around prohibiting eligibility periods of more than 6 months. This PCN gives each jurisdiction the authority to establish their own eligibility timeframes and guidelines within federal permittable standards.

2. As a result of this change, the Illinois Department of Public Health has determined several changes will be made to not only move to a longer eligibility period but also take several steps to streamline the process and reduce the amount of required information and paperwork.

3. These changes will be outlined in detail on the following slides.

4

4

WHAT CHANGES ARE COMING?

- Changes to the Eligibility Cycle
- Implementation of an Eligibility Attestation
- Changes to Conditional 90 Day Approvals
- Reduce Amount of Required Paperwork
- Require a Method of Client Contact
- Streamline the Eligibility Assessment and Client Profile

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ELIGIBILITY CYCLE

- Currently, program participants are given what is referred to as a rolling enrollment period or cycle. This means that, when approved, the program participant is given an eligibility expiration date based on the month when the approval was granted and/or their current eligibility expiration date.
  - For example, if they are new to the program and approved on May 15, 2022, their eligibility expiration date would be set to October 31, 2022.
- With the changes being made by the Program, the eligibility expiration date will now be based on the program participant's birth month.
  - Now, if they are new to the program, are approved on May 15, 2023 and their birth month is June, their eligibility expiration date would be set to June 30, 2024.

6

6

ELIGIBILITY CYCLE

The table below provides some more examples of how the Program will begin calculating eligibility expiration dates based on birth month.

Birth Month	Approval Date	Expiration Date
January	May 2023	January 31, 2024
February	May 2023	February 28, 2024
March	May 2023	March 31, 2024
April	May 2023	April 30, 2024
May	May 2023	May 31, 2024
June	May 2023	June 30, 2024
July	May 2023	July 31, 2024

7

7

ELIGIBILITY CYCLE

The table below provides some more examples of how the Program will begin calculating eligibility expiration dates based on birth month.

Birth Month	Approval Date	Expiration Date
August	May 2023	August 31, 2024
September	May 2023	September 30, 2024
October	May 2023	October 31, 2024
November	May 2023	November 30, 2023
December	May 2023	December 31, 2023

8

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ELIGIBILITY CYCLE

- No matter when the program participant is approved, their eligibility expiration date will be aligned with their next birth month. The only exception to this is when it is a conditional approval.
- Unless the approval is conditional, program participants will not receive less than 6 months of eligibility.
- This should make it easier for program participants to remember when to reapply. Program participants will be able to start their reapplication starting on the 1st day of their birth month to avoid interruptions to their eligibility.

9

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QUESTIONS?

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ELIGIBILITY ATTESTATION

- To streamline the eligibility redetermination process, the Program will be implementing what it is calling an Eligibility Attestation.
  - The Eligibility Attestation will be a simplified and streamlined version of the Eligibility Assessment allowing the program participant to attest to certain eligibility information like income, residency and insurance coverage so long as this information has NOT changed since their last eligibility determination.
- If this is the case, the program participant will be able to attest to this and no further information or documentation will be needed for that information.
- If there have been changes to this information, the program participant will indicate this and will be required to provide updated information and must provide new supporting documentation.

11

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ELIGIBILITY ATTESTATION

This new attestation will **only** be available during every other reapplication. In other words, program participants can alternate between a full Eligibility Assessment and the new Eligibility Attestation. Program participants will not be able to reapply using the Eligibility Attestation if that is what they used to reapply the last time.

This new attestation is **only** available to program participants who are currently enrolled in the Program, are reapplying, and meet one of the criteria below:

1. Currently enrolled in case management with one of our funded case management service providers.
2. Has an active web user account.

12

12

ELIGIBILITY ATTESTATION

Program participants who do not meet this criteria or have a disruption in their eligibility will NOT be able to use the attestation and must continue to use the full Eligibility Assessment each time they apply/reapply.

The Program will be providing additional guidance and training opportunities once this feature is fully implemented.

13

13

QUESTIONS?

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14

CONDITIONAL APPROVALS

The Program understands the need to continue allowing conditional approvals for specific situations and circumstances. Therefore, the Program will continue to grant conditional approvals for the following conditions only:

- Missing Viral Load Labs
- Missing Proof of HIV for Case Management Only
  - Not available when enrolling in Medication or Premium Assistance

15

15

CONDITIONAL APPROVALS

Viral Load Lab Results

Individuals who apply/reapply and do not provide documentation on viral load lab results within the six months prior to the submission of their Eligibility Assessment will only be given a conditional approval for 90 days.

During these 90 days, the individual must obtain these required lab results and provide this information and documentation to the Program. Failure to do so before the end of this 90 days will result in eligibility being terminated and, in order to restore eligibility, a full Eligibility Assessment will be required with complete viral load documentation.

16

16

CONDITIONAL APPROVALS

Proof of HIV

Individuals who apply and do not provide documentation of their HIV/AIDS diagnosis will be given a conditional approval for 90 days. During these 90 days, the individual must obtain and provide this documentation to the Program before the end of this 90 days.

Failure to do so will result in eligibility being terminated and, in order to restore eligibility, a full Eligibility Assessment will be required with complete viral load documentation.

During this conditional enrollment, Medication and Premium Assistance services will **NOT** be available. However, services to assist the individual in obtaining this documentation can be provided.

17

17

CONDITIONAL APPROVALS

Program Participants will not be granted back to back conditional approvals for the same reason.

18

18

QUESTIONS?

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19

REQUIRED PAPERWORK

In order to reduce the amount of paperwork required, the Program has created a new comprehensive form called the Program Agreement. This form will contain all current language from the Authorization to Release as well as additional language outlining information on income, residency and insurance requirements.

This new form allows the Program to eliminate the following forms:

- Authorization to Release and Privacy Practice
- No Insurance Affidavit
- Verification of Residency Form
- Household Income Statement

20

20

REQUIRED PAPERWORK

The new Program Agreement form is required to be signed, dated, and submitted with every Eligibility Assessment and every Eligibility Attestation.

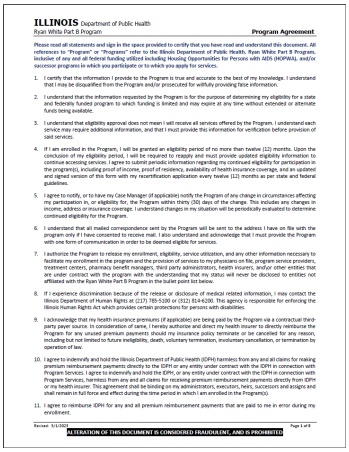
NO EXCEPTIONS!

21

21

REQUIRED PAPERWORK

We will now review and discuss the Program Agreement form in detail.



ILLINOIS Department of Public Health
Ryan White Part B Program

Program Agreement

Please read all statements and sign in the space provided to certify that you have read and understand this document. All references to "Program" or "Programs" refer to the Illinois Department of Public Health, Ryan White Part B Program, inclusive of any and all federal funding utilized including Housing Opportunities for Persons with AIDS (HOPWA), and/or successor programs in which you participate or to which you apply for services.

1. I certify that the information I provide to the Program is true and accurate to the best of my knowledge. I understand that I may be disqualified from the Program and/or prosecuted for willfully providing false information.
2. I understand that the information requested by the Program is for the purpose of determining my eligibility for a state and federally funded program to which funding is limited and may expire at any time without extended or alternate funds being available.
3. I understand that eligibility approval does not mean I will receive all services offered by the Program. I understand each service may require additional information, and that I must provide this information for verification before provision of said services.
4. If I am enrolled in the Program, I will be granted an eligibility period of no more than twelve (12) months. Upon the conclusion of my eligibility period, I will be required to reapply and must provide updated eligibility information to continue accessing services. I agree to submit periodic information regarding my continued eligibility for participation in the program(s), including proof of income, proof of residency, availability of health insurance coverage, and an updated and signed version of this form with my recertification application every twelve (12) months as per state and federal guidelines.
5. I agree to notify, or to have my Case Manager (if applicable) notify the Program of any change in circumstances affecting my participation in, or eligibility for, the Program within thirty (30) days of the change. This includes any changes in income, address or insurance coverage. I understand changes in my situation will be periodically evaluated to determine continued eligibility for the Program.
6. I understand that all mailed correspondence sent by the Program will be sent to the address I have on file with the program only if I have consented to receive mail. I also understand and acknowledge that I must provide the Program with one form of communication in order to be deemed eligible for services.
7. I authorize the Program to release my enrollment, eligibility, service utilization, and any other information necessary to facilitate my enrollment in the program and the provision of services to my physicians on file, program service providers, treatment centers, pharmacy benefit managers, third party administrators, health insurers, and/or other entities that are under contract with the program with the understanding that my status will never be disclosed to entities not affiliated with the Ryan White Part B Program in the bullet point list below.
8. If I experience discrimination because of the release or disclosure of medical related information, I may contact the Illinois Department of Human Rights at (217) 785-5100 or (312) 814-6200. This agency is responsible for enforcing the Illinois Human Rights Act which provides certain protections for persons with disabilities.
9. I acknowledge that my health insurance premiums (if applicable) are being paid by the Program via a contractual third-party payer source. In consideration of same, I hereby authorize and direct my health insurer to directly reimburse the Program for any unused premium payments should my insurance policy 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.
10. I agree to indemnify and hold the Illinois Department of Public Health (IDPH) harmless from any and all claims for making premium reimbursement payments directly to the IDPH or any entity under contract with the IDPH in connection with Program Services. I agree to indemnify and hold the IDPH, or any entity under contract with the IDPH in connection with Program Services, harmless from any and all claims for receiving premium reimbursement payments directly from IDPH or my health insurer. 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(s).
11. I agree to reimburse IDPH for any and all premium reimbursement payments that are paid to me in error during my enrollment.

Revised: 5/1/2021 ALTERATION OF THIS DOCUMENT IS CONSIDERED FRAUDULENT, AND IS PROHIBITED Page 1 of 8

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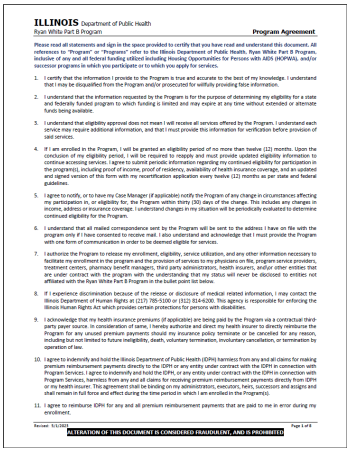
REQUIRED PAPERWORK

- The first section of the new Program Agreement form contains fourteen (14) points outlining critical information about the program and its operation.
- Be sure the program participant reads these items in full and ensure they completely understand these items before they sign and date this document.
- Failure to comply with these items may result in termination of eligibility for the program.



ILLINOIS Department of Public Health
Ryan White Part B Program — **Program Agreement**

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1. I certify that the information I provide to the Program is true and accurate to the best of my knowledge. I understand that I may be disqualified from the Program and/or prosecuted for willfully providing false information.
2. I understand that the information requested by the Program is for the purpose of determining my eligibility for a state and federally funded program to which funding is limited and may expire at any time without extended or alternate funds being available.
3. I understand that eligibility approval does not mean I will receive all services offered by the Program. I understand each service may require additional information, and that I must provide this information for verification before provision of said services.
4. If I am enrolled in the Program, I will be granted an eligibility period of no more than twelve (12) months. Upon the conclusion of my eligibility period, I will be required to reapply and must provide updated eligibility information to continue accessing services. I agree to submit periodic information regarding my continued eligibility for participation in the program(s), including proof of income, proof of residency, availability of health insurance coverage, and an updated and signed version of this form with my recertification application every twelve (12) months as per state and federal guidelines.
5. I agree to notify, or to have my Case Manager (if applicable) notify the Program of any change in circumstances affecting my participation in, or eligibility for, the Program within thirty (30) days of the change. This includes any changes in income, address or insurance coverage. I understand changes in my situation will be periodically evaluated to determine continued eligibility for the Program.
6. I understand that all mailed correspondence sent by the Program will be sent to the address I have on file with the program only if I have consented to receive mail. I also understand and acknowledge that I must provide the Program with one form of communication in order to be deemed eligible for services.
7. I authorize the Program to release my enrollment, eligibility, service utilization, and any other information necessary to facilitate my enrollment in the program and the provision of services to my physicians on file, program service providers, treatment centers, pharmacy benefit managers, third party administrators, health insurers, and/or other entities that are under contract with the program with the understanding that my status will never be disclosed to entities not affiliated with the Ryan White Part B Program in the bullet point list below.
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9. I acknowledge that my health insurance premiums (if applicable) are being paid by the Program via a contractual third-party payer source. In consideration of same, I hereby authorize and direct my health insurer to directly reimburse the Program for any unused premium payments should my insurance policy 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.
10. I agree to indemnify and hold the Illinois Department of Public Health (IDPH) harmless from any and all claims for making premium reimbursement payments directly to the IDPH or any entity under contract with the IDPH in connection with Program Services. I agree to indemnify and hold the IDPH, or any entity under contract with the IDPH in connection with Program Services, harmless from any and all claims for receiving premium reimbursement payments directly from IDPH or my health insurer. 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(s).
11. I agree to reimburse IDPH for any and all premium reimbursement payments that are paid to me in error during my enrollment.

Revised: 5/1/2021 — Page 1 of 8
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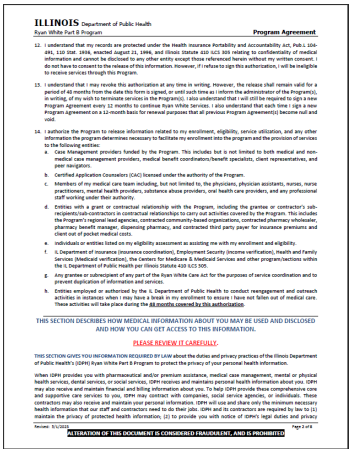
REQUIRED PAPERWORK

- The next section of the new Program Agreement form starts at the bottom of page 2 and continues until page 5.
- This section contains information about how the Program obtains and uses the medical information it collects about the program participant.
- It also outlines their rights as a participant in the program.



ILLINOIS Department of Public Health
Ryan White Part B Program — **Program Agreement**

12. I understand that my records are protected under the Health Insurance Portability and Accountability Act, Pub.L.104-191, 110 Stat. 1936, enacted August 21, 1996, and Illinois Statute 410 ILCS 305 relating to confidentiality of medical information and cannot be disclosed to any other entity except those referenced herein without my written consent. I do not have to consent to the release of this information. However, if I refuse to sign this authorization, I will be ineligible to receive services through this Program.
13. I understand that I may revoke this authorization at any time in writing. However, the release shall remain valid for a period of 48 months from the date this form is signed, or until such time as I inform the administrator of the Program(s), in writing, of my wish to terminate services in the Program(s). I also understand that I will still be required to sign a new Program Agreement every 12 months to continue Ryan White Services. I also understand that each time I sign a new Program Agreement on a 12-month basis for renewal purposes that all previous Program Agreement(s) become null and void.
14. I authorize the Program to release information related to my enrollment, eligibility, service utilization, and any other information the program determines necessary to facilitate my enrollment into the program and the provision of services to the following entities:
    a. Case Management providers funded by the Program. This includes but is not limited to both medical and non-medical case management providers, medical benefit coordinators/benefit specialists, client representatives, and peer navigators.
    b. Certified Application Counselors (CAC) licensed under the authority of the Program.
    c. Members of my medical care team including, but not limited to, the physicians, physician assistants, nurses, nurse practitioners, mental health providers, substance abuse providers, oral health care providers, and any professional staff working under their authority.
    d. Entities with a grant or contractual relationship with the Program, including the grantee or contractor's sub-recipients/sub-contractors in contractual relationships to carry out activities covered by the Program. This includes the Program's regional lead agencies, contracted community-based organizations, contracted pharmacy wholesaler, pharmacy benefit manager, dispensing pharmacy, and contracted third party payer for insurance premiums and client out of pocket medical costs.
    e. Individuals or entities listed on my eligibility assessment as assisting me with my enrollment and eligibility.
    f. IL Department of Insurance (insurance coordination), Employment Security (income verification), Health and Family Services (Medicaid verification), the Centers for Medicare & Medicaid Services and other programs/sections within the IL Department of Public Health per Illinois Statute 410 ILCS 509.
    g. Any grantee or subrecipient of any part of the Ryan White Care Act for the purposes of service coordination and to prevent duplication of information and services.
    h. Entities employed or authorized by the IL Department of Public Health to conduct reengagement and outreach activities in instances when I may have a break in my enrollment to ensure I have not fallen out of medical care. These activities will take place during the 48 months covered by this authorization.

THIS SECTION DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THIS SECTION GIVES YOU INFORMATION REQUIRED BY LAW about the duties and privacy practices of the Illinois Department of Public Health's (IDPH) Ryan White Part B Program to protect the privacy of your personal health information.

When IDPH provides you with pharmaceutical and/or premium assistance, medical case management, mental or physical health services, dental services, or social services, IDPH receives and maintains personal health information about you. IDPH may also receive and maintain financial and billing information about you. To help IDPH provide these comprehensive care and supportive care services to you, IDPH may contract with companies, social service agencies, or individuals. These contractors may also receive and maintain your personal information. IDPH will use and share only the minimum necessary health information that our staff and contractors need to do their jobs. IDPH and its contractors are required by law to: (1) maintain the privacy of protected health information; (2) to provide you with notice of IDPH's legal duties and privacy

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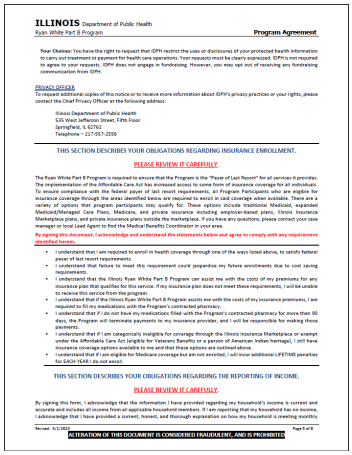
REQUIRED PAPERWORK

- The next section of the new Program Agreement form starts and ends on page 5.
- This section contains information about the program participant's responsibilities when it comes to enrolling in appropriate insurance coverage and how that relates to the Program's payer of last resort requirement.



ILLINOIS Department of Public Health
Ryan White Part B Program
Program Agreement

Your Choices: You have the right to request that IDPH restrict the uses or disclosures of your protected health information to carry out treatment or payment for health care operations. Your requests must be clearly expressed. IDPH is not required to agree to your requests. IDPH does not engage in fundraising. However, you may opt out of receiving any fundraising communication from IDPH.

PRIVACY OFFICER
To request additional copies of this notice or to receive more information about IDPH's privacy practices or your rights, please contact the Chief Privacy Officer at the following address:

Illinois Department of Public Health
535 West Jefferson Street, Fifth Floor
Springfield, IL 62761
Telephone – 217-557-2556

THIS SECTION DESCRIBES YOUR OBLIGATIONS REGARDING INSURANCE ENROLLMENT.

PLEASE REVIEW IT CAREFULLY.

The Ryan White Part B Program is required to ensure that the Program is the "Payer of Last Resort" for all services it provides. The implementation of the Affordable Care Act has increased access to some form of insurance coverage for all individuals. To ensure compliance with the federal payer of last resort requirements, all Program Participants who are eligible for insurance coverage through the areas identified below are required to enroll in said coverage when available. There are a variety of options that program participants may qualify for. These options include traditional Medicaid, expanded Medicaid/Managed Care Plans, Medicare, and private insurance including employer-based plans, Illinois Insurance Marketplace plans, and private insurance plans outside the marketplace. If you have any questions, please contact your case manager or local Lead Agent to find the Medical Benefits Coordinator in your area.

By signing this document, I acknowledge and understand the statements below and agree to comply with any requirement identified herein.

- I understand that I am required to enroll in health coverage through one of the ways listed above, to satisfy federal payer of last resort requirements.
- I understand that failure to meet this requirement could jeopardize my future enrollments due to cost saving requirements.
- I understand that the Illinois Ryan White Part B Program can assist me with the costs of my premiums for any insurance plan that qualifies for this service. If my insurance plan does not meet these requirements, I will be unable to receive this service from the program.
- I understand that if the Illinois Ryan White Part B Program assists me with the costs of my insurance premiums, I am required to fill my medications with the Program's contracted pharmacy.
- I understand that if I do not have my medications filled with the Program's contracted pharmacy for more than 90 days, the Program will terminate payments to my insurance provider, and I will be responsible for making those payments.
- I understand that if I am categorically ineligible for coverage through the Illinois Insurance Marketplace or exempt under the Affordable Care Act (eligible for Veterans Benefits or a person of American Indian heritage), I will have insurance coverage options available to me and that these options are outlined above.
- I understand that if I am eligible for Medicare coverage but am not enrolled, I will incur additional LIFETIME penalties for EACH YEAR I do not enroll.

THIS SECTION DESCRIBES YOUR OBLIGATIONS REGARDING THE REPORTING OF INCOME.

PLEASE REVIEW IT CAREFULLY.

By signing this form, I acknowledge that the information I have provided regarding my household's income is current and accurate and includes all income from all applicable household members. If I am reporting that my household has no income, I acknowledge that I have provided a current, honest, and thorough explanation on how my household is meeting monthly

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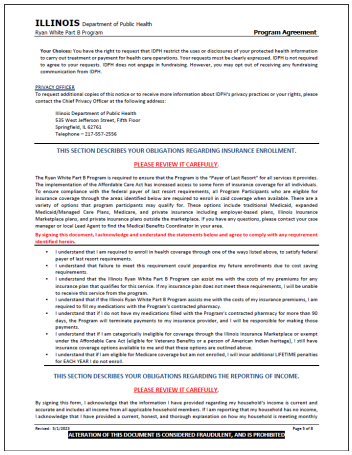
REQUIRED PAPERWORK

- The next section of the new Program Agreement form starts on the bottom of page 5 and ends on page 6.
- This section contains information about the program participants responsibilities when it comes to reporting household income to the program.



ILLINOIS Department of Public Health
Ryan White Part B Program
Program Agreement

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- I understand that failure to meet this requirement could jeopardize my future enrollments due to cost saving requirements.
- I understand that the Illinois Ryan White Part B Program can assist me with the costs of my premiums for any insurance plan that qualifies for this service. If my insurance plan does not meet these requirements, I will be unable to receive this service from the program.
- I understand that if the Illinois Ryan White Part B Program assists me with the costs of my insurance premiums, I am required to fill my medications with the Program's contracted pharmacy.
- I understand that if I do not have my medications filled with the Program's contracted pharmacy for more than 90 days, the Program will terminate payments to my insurance provider, and I will be responsible for making those payments.
- I understand that if I am categorically ineligible for coverage through the Illinois Insurance Marketplace or exempt under the Affordable Care Act (eligible for Veterans Benefits or a person of American Indian heritage), I will have insurance coverage options available to me and that these options are outlined above.
- I understand that if I am eligible for Medicare coverage but am not enrolled, I will incur additional LIFETIME penalties for EACH YEAR I do not enroll.

THIS SECTION DESCRIBES YOUR OBLIGATIONS REGARDING THE REPORTING OF INCOME.

PLEASE REVIEW IT CAREFULLY.

By signing this form, I acknowledge that the information I have provided regarding my household's income is current and accurate and includes all income from all applicable household members. If I am reporting that my household has no income, I acknowledge that I have provided a current, honest, and thorough explanation on how my household is meeting monthly

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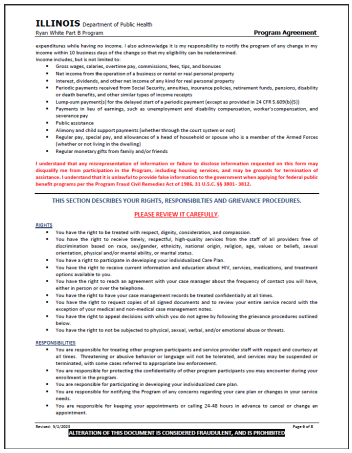
REQUIRED PAPERWORK

- The next section of the new Program Agreement form starts on the bottom of page 6 and ends on page 7.
- This section outlines the program participant's rights and responsibilities and outlines the Program's grievance procedure.



ILLINOIS Department of Public Health
Ryan White Part B Program — **Program Agreement**

expenditures while having no income. I also acknowledge it is my responsibility to notify the program of any change in my income within 10 business days of the change so that my eligibility can be redetermined.
Income includes, but is not limited to:

- Gross wages, salaries, overtime pay, commissions, fees, tips, and bonuses
- Net income from the operation of a business or rental or real personal property
- Interest, dividends, and other net income of any kind for real personal property
- Periodic payments received from Social Security, annuities, insurance policies, retirement funds, pensions, disability or death benefits, and other similar types of income receipts
- Lump-sum payment(s) for the delayed start of a periodic payment (except as provided in 24 CFR 5.609(b)(5))
- Payments in lieu of earnings, such as unemployment and disability compensation, worker's compensation, and severance pay
- Public assistance
- Alimony and child support payments (whether through the court system or not)
- Regular pay, special pay, and allowances of a head of household or spouse who is a member of the Armed Forces (whether or not living in the dwelling)
- Regular monetary gifts from family and/or friends

I understand that any misrepresentation of information or failure to disclose information requested on this form may disqualify me from participation in the Program, including housing services, and may be grounds for termination of assistance. I understand that it is unlawful to provide false information to the government when applying for federal public benefit programs per the Program Fraud Civil Remedies Act of 1986, 31 U.S.C. §§ 3801–3812.

THIS SECTION DESCRIBES YOUR RIGHTS, RESPONSIBILITIES AND GRIEVANCE PROCEDURES.

PLEASE REVIEW IT CAREFULLY.

RIGHTS

- You have the right to be treated with respect, dignity, consideration, and compassion.
- You have the right to receive timely, respectful, high-quality services from the staff of all providers free of discrimination based on race, sex/gender, ethnicity, national origin, religion, age, values or beliefs, sexual orientation, physical and/or mental ability, or marital status.
- You have a right to participate in developing your individualized Care Plan.
- You have the right to receive current information and education about HIV, services, medications, and treatment options available to you.
- You have the right to reach an agreement with your case manager about the frequency of contact you will have, either in person or over the telephone.
- You have the right to have your case management records be treated confidentially at all times.
- You have the right to request copies of all signed documents and to review your entire service record with the exception of your medical and non-medical case management notes.
- You have the right to appeal decisions with which you do not agree by following the grievance procedures outlined below.
- You have the right to not be subjected to physical, sexual, verbal, and/or emotional abuse or threats.

RESPONSIBILITIES

- You are responsible for treating other program participants and service provider staff with respect and courtesy at all times. Threatening or abusive behavior or language will not be tolerated, and services may be suspended or terminated, with some cases referred to appropriate law enforcement.
- You are responsible for protecting the confidentiality of other program participants you may encounter during your enrollment in the program.
- You are responsible for participating in developing your individualized care plan.
- You are responsible for notifying the Program of any concerns regarding your care plan or changes in your service needs.
- You are responsible for keeping your appointments or calling 24-48 hours in advance to cancel or change an appointment.

Revised: 5/1/2021 — ALTERATION OF THIS DOCUMENT IS CONSIDERED FRAUDULENT, AND IS PROHIBITED — Page 6 of 8

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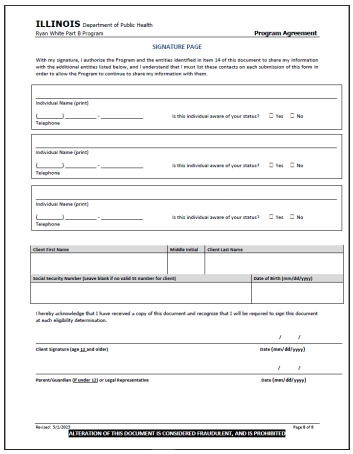
REQUIRED PAPERWORK

- The last page of the new Program Agreement is the signature page.
- This page allows the program participant to provide the Program with the names and contact information on as many as three individual people who they authorize the Program to share their information with.
- Once they have read and fully understand the contents of this document, they must sign and date the form at the bottom of this page.
- **Only a copy of the last page needs to be provide to the Program with the assessment.**



ILLINOIS Department of Public Health
Ryan White Part B Program — **Program Agreement**

SIGNATURE PAGE

With my signature, I authorize the Program and the entities identified in Item 24 of this document to share my information with the additional entities listed below, and I understand that I must list these contacts on each submission of this form in order to allow the Program to continue to share my information with them.

Individual Name (print)
( ) - Telephone — Is this individual aware of your status? ☐ Yes ☐ No

Individual Name (print)
( ) - Telephone — Is this individual aware of your status? ☐ Yes ☐ No

Individual Name (print)
( ) - Telephone — Is this individual aware of your status? ☐ Yes ☐ No

Client First Name	Middle Initial	Client Last Name

Social Security Number (Leave blank if no valid SS number for client)	Date of Birth (mm/dd/yyyy)

I hereby acknowledge that I have received a copy of this document and recognize that I will be required to sign this document at each eligibility determination.

Client Signature (age 12 and older) — Date (mm/dd/yyyy)

Parent/Guardian (if under 12) or Legal Representative — Date (mm/dd/yyyy)

Revised: 5/1/2021 — ALTERATION OF THIS DOCUMENT IS CONSIDERED FRAUDULENT, AND IS PROHIBITED — Page 8 of 8

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REQUIRED PAPERWORK

There have been no changes to documentation requirements for Premium Assistance.

- When requesting Premium Assistance, premium documentation must always be submitted.
- This documentation must outline the regular premium amount, frequency of payment, any information on past due amounts, and where to send the payments.

There have been no changes to the Revocation of Authorization to Release.

29

29

QUESTIONS?

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30

METHOD OF CONTACT

- One of the major challenges for the Program is the need to be able to provide program participants with critical and time sensitive information. Without a mechanism to do this, program participants can miss important deadlines and program changes which can cause disruptions in eligibility and service provisions such as premium assistance.
- To minimize this, the Program has implemented a requirement for all participants to provide at least one method of contact that can be used to provide them with any critical and time sensitive information the Program deems necessary.
- Program participants will be able to choose how they wish to receive this communication.

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METHOD OF CONTACT

The four available methods of contact are:

- Mail
- Phone Call/Voicemail
- Email
- Text Message

Program participants must choose at least one of these options but can select as may contact methods as they want. Once selected, they will have the ability to provide the details such as their mailing address, email, phone numbers, etc.

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METHOD OF CONTACT

- Program participants who are unhoused/homeless can work with the funded case management providers in their area and can receive assistance for prepaid cell phones, signing up for email accounts, etc.
- These service providers can assist clients with establishing one of the allowable contact methods.

33

33

METHOD OF CONTACT

- By applying/reapplying to the Program, program participants are agreeing to share their contact information with the Program and allowing the Program to use this information to contact them and provide them with information about their eligibility, insurance open enrollment periods, service provisions and other miscellaneous program updates.
- This communication, both written and verbal, may contain words or phrases such as HIV, AIDS, or Ryan White.
- Therefore, program participants must be sure to select an option that works best for them and their situation. Providing false information to the Program may result in your personal health information being shared with unintended individuals.

34

34

METHOD OF CONTACT

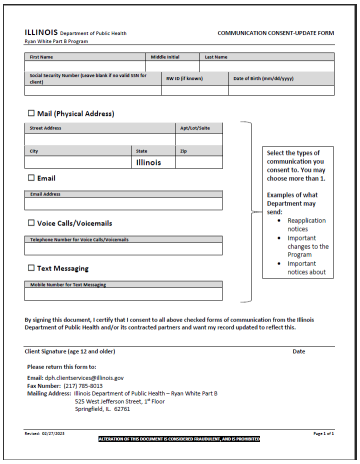
- If a change of this information is warranted during eligibility, program participants have two ways of getting this information updated.
- First, they can enroll with a program funded case management provider. These service providers have access to this information and can make direct changes on behalf of program participants.
- Second, for program participants who do not have a case manager and do not want to enroll with a case manager, a ***Communication Consent Update Form*** must be completed, signed and dated, and sent to the Program. Once received, the Program will update this information and save a copy of the form in the client file. This form, as well as all new forms will be available on the Eligibility Assessment website landing page.

35

35

METHOD OF CONTACT

- We will now review and discuss the Communication Consent Update form.



ILLINOIS Department of Public Health
Ryan White Part B Program

COMMUNICATION CONSENT-UPDATE FORM

First Name	Middle Initial	Last Name
Social Security Number (Leave blank if no valid SSN for client)	HIV ID (if known)	Date of Birth (mm/dd/yyyy)

☐ Mail (Physical Address)

Street Address	Apt/Unit/Suite
City	State / Zip
	Illinois

☐ Email

Email Address

☐ Voice Calls/Voicemails

Telephone Number for Voice Calls/Voicemails

☐ Text Messaging

Mobile Number for Text Messaging

Select the types of communication you consent to. You may choose more than 1.

Examples of what Department may send:
- Reapplication notices
- Important changes to the Program
- Important notices about

By signing this document, I certify that I consent to all above checked forms of communication from the Illinois Department of Public Health and/or its contracted partners and want my record updated to reflect this.

Client Signature (age 12 and older) Date

Please return this form to:
Email: dph.clientservices@illinois.gov
Fax Number: (217) 705-8013
Mailing Address: Illinois Department of Public Health – Ryan White Part B
525 West Jefferson Street, 1st Floor
Springfield, IL 62761

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ALTERATION OF THIS DOCUMENT IS CONSIDERED FRAUDULENT, AND IS PROHIBITED

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METHOD OF CONTACT

The top section of this form must be completed with the program participant's information.

First Name	Middle Initial	Last Name

Social Security Number (Leave blank if no valid SSN for client)	RW ID (if known)	Date of Birth (mm/dd/yyyy)

37

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METHOD OF CONTACT

- The next section of this form requires the selection of the desired method(s) of contact.
- At least on method must be selected.
- Multiple methods can also be selected if the program participant wishes to receive communication in multiple ways.

☐ **Mail (Physical Address)**

Street Address		Apt/Lot/Suite
City	**State**	**Zip**
	Illinois	

☐ **Email**

Email Address

☐ **Voice Calls/Voicemails**

Telephone Number for Voice Calls/Voicemails

☐ **Text Messaging**

Mobile Number for Text Messaging

Select the types of communication you consent to. You may choose more than 1.

Examples of what Department may send:

- Reapplication notices
- Important changes to the Program
- Important notices about

38

38

METHOD OF CONTACT

The last section of this form is where the program participant must sign and date.

By signing this document, I certify that I consent to all above checked forms of communication from the Illinois Department of Public Health and/or its contracted partners and want my record updated to reflect this.

Client Signature (age 12 and older) **Date**

Please return this form to:

Email: dph.clientservices@illinois.gov
Fax Number: (217) 785-8013
Mailing Address: Illinois Department of Public Health – Ryan White Part B
525 West Jefferson Street, 1st Floor
Springfield, IL. 62761

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METHOD OF CONTACT

This form must be returned to the Program using one of the following methods.

- Email (DPH.ClientServices@illinois.gov)
- Fax (217-785-8013)
- Mail to: Illinois Department of Public Health – Ryan White Part B
  525 West Jefferson, 1st Floor
  Springfield, IL 62761

40

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QUESTIONS?

41

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ELIGIBILITY ASSESSMENT

- In order to simplify, streamline and reduce the amount of information needed to determine eligibility, the Program has made several changes to how information is collected on the Eligibility Assessment both online and within the data system.
- The following slides contain basic information on the changes made to each tab on the Eligibility Assessment and can be referenced at a later date.
- **However, for this training, we will now conduct a visual demonstration of the Eligibility Assessment.**
- Once the visual demonstration is completed, we will return to the presentation.

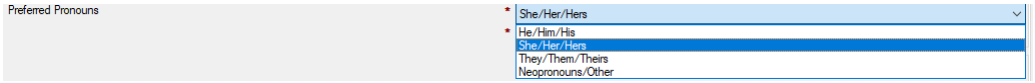
42

42

ELIGIBILITY ASSESSMENT

Main Tab Changes

The Program has added a field to collect the applicant's preferred pronouns.



Choosing the "Neopronouns/Other" option will allow the applicant to specify their preferred pronouns.

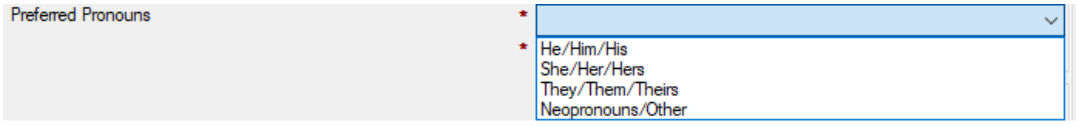
43

43

ELIGIBILITY ASSESSMENT

Main Tab Changes

The Program has added a field to collect the applicant's preferred pronouns.



Choosing the "Neopronouns/Other" option will allow the applicant to specify their preferred pronouns.

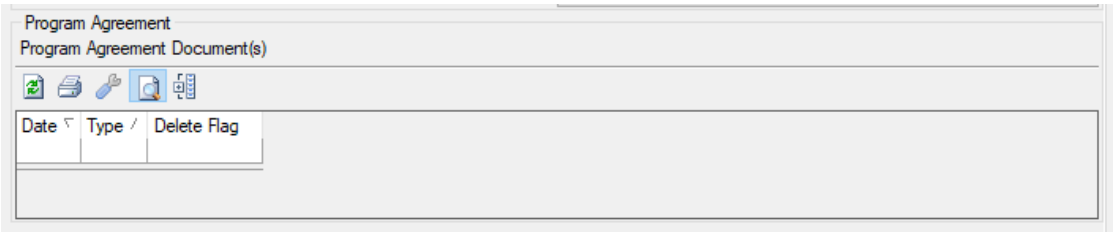
44

44

ELIGIBILITY ASSESSMENT

Main Tab Changes - continued

At the bottom of the tab, there is a section to allow the upload of the new Program Agreement.



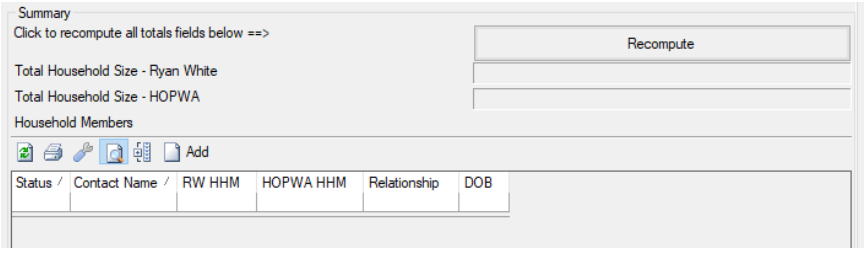
45

45

ELIGIBILITY ASSESSMENT

Demographic Changes

The Program has removed the Household tab and moved the information on this tab to the bottom of the Demo tab. This was done to streamline the assessment and to ensure all related information is grouped together to more accurately determine household size.



46

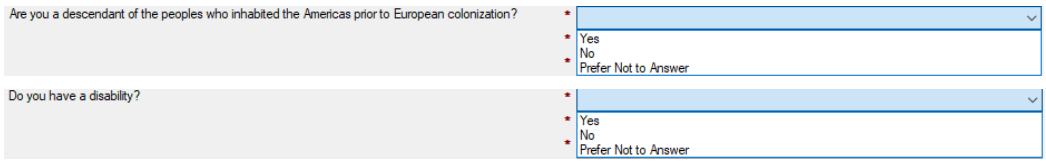
46

ELIGIBILITY ASSESSMENT

Demographic Changes - continued

In response to the Data Governance and Organization to Support Equity and Racial Justice Act (20 ILCS 65), the Program has also added two new questions to this tab.

These questions ask about being a descendent of people who inhabited the Americas prior to European colonization and about having a disability.



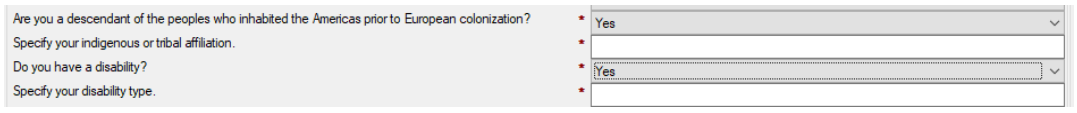
47

47

ELIGIBILITY ASSESSMENT

Demographic Changes - continued

Answering yes to these questions will allow the applicant to specify their indigenous or tribal affiliation and their disability type.



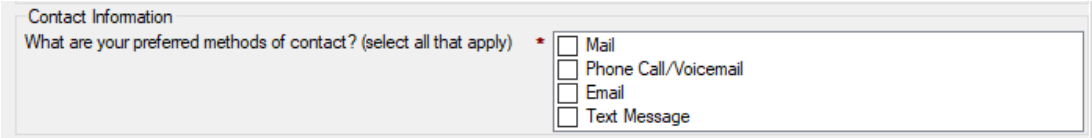
48

48

ELIGIBILITY ASSESSMENT

Residence Changes

The Residence tab has been renamed to Address and updated to require all program participants to provide a way for the Program to contact them. Program participants can choose more than one method of contact, but must choose at least.



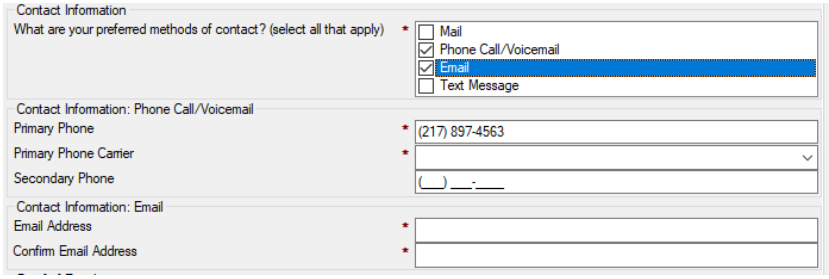
49

49

ELIGIBILITY ASSESSMENT

Residence Changes - continued

Options are phone/voicemail, email, text, or mail. After selecting an option, the applicant will be required to provide the detail for this method.



50

50

ELIGIBILITY ASSESSMENT

Residence Changes - continued

- The Program will begin to use these methods to contact program participants regarding important program updates, deadlines, and other critical information.
- This communication, both written and verbal, may contain words or phrases such as HIV, AIDS, or Ryan White.
- Therefore, program participants must be sure to select an option that works best for them and their situation. Providing false information to the Program may result in your personal health information being shared with unintended individuals.

51

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ELIGIBILITY ASSESSMENT

Insurance Changes

- The Program will no longer be collecting detailed insurance information such as insurance carrier, plan name, group number, RX Bin, etc.
- Instead, the Program will ask simple questions to determine if the program participant has insurance, what type(s) of insurance coverage do they have, and how did they obtain this coverage.

52

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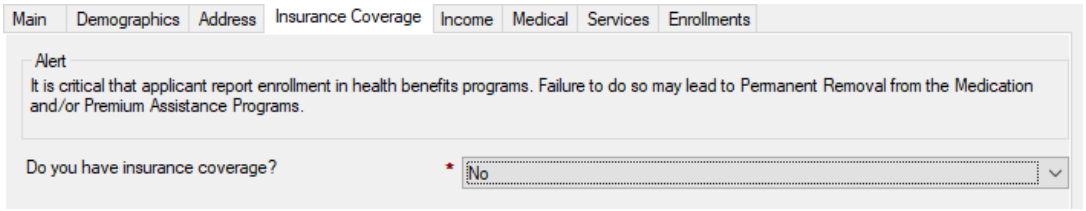
ELIGIBILITY ASSESSMENT

Insurance Changes - continued

In the example below, you can see how this tab will look if the client has no insurance.



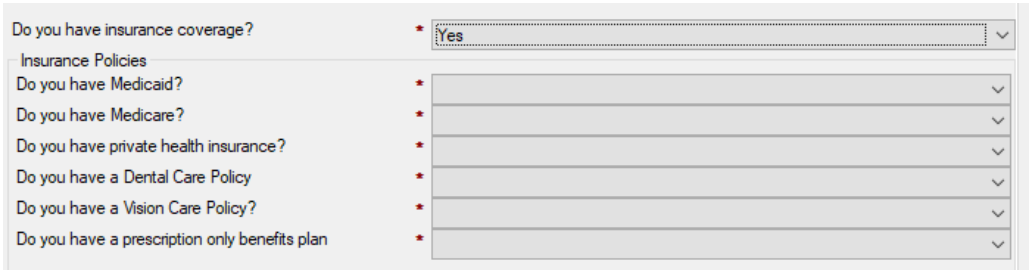
53

53

ELIGIBILITY ASSESSMENT

Insurance Changes - continued

In the example below, you can see how this tab will look if the client has insurance.



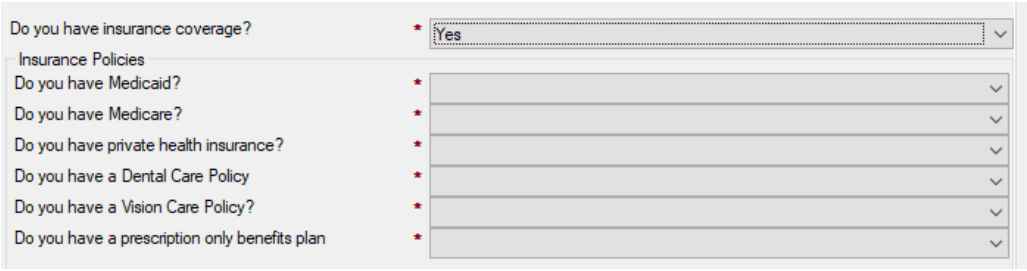
54

54

ELIGIBILITY ASSESSMENT

Insurance Changes - continued

Notice the individual questions for each type of insurance. This allows the applicant to specify which insurance type then have.



55

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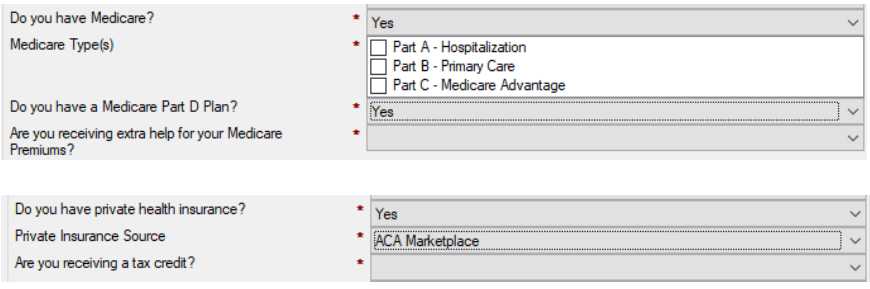
ELIGIBILITY ASSESSMENT

Insurance Changes - continued

Selecting yes to any of these types may require more information.



56

56

ELIGIBILITY ASSESSMENT

Income Changes

- The Program has also made several changes to how household income is collected. The assessment will now ask if the household has any income. If the answer is yes, each source of income will be documented separately.
- This allows the system to only require information if the household has income. In other words, if there are two sources of income, the only information we collect is for these two income sources.
- Similarly, the Program collects information on qualifying adjustments. The assessment will now ask if the household has any income adjustments. If the answer is yes, each source of income adjustment will be documented separately.

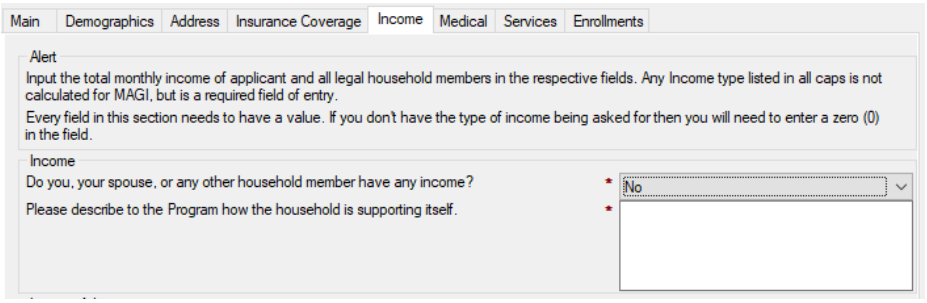
57

57

ELIGIBILITY ASSESSMENT

Income Changes - continued

If the program participant is reporting the household has no income, a narrative describing how the household is supporting itself must be provided.



58

58

ELIGIBILITY ASSESSMENT

Income Changes - continued

Below is an example of an applicant who has multiple sources of income.

Applicants must document all sources of income and report the monthly gross amount.

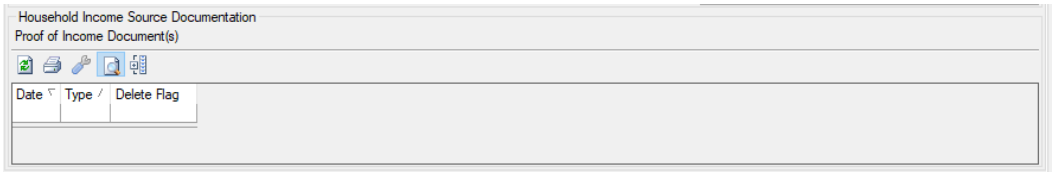
59

59

ELIGIBILITY ASSESSMENT

Income Changes - continued

Once the sources are documented, the supporting documentation must be provided.



60

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ELIGIBILITY ASSESSMENT

Income Changes - continued

This process works the same way for the income adjustments.

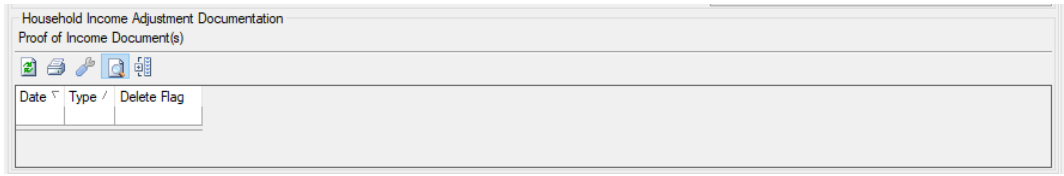
61

61

ELIGIBILITY ASSESSMENT

Income Changes - continued

Including a place to provide supporting documentation for the adjustments.



62

62

ELIGIBILITY ASSESSMENT

Income Changes - continued

A few things to remember:

- All income from all household members must be reported in each source of income.
- Income is reported as gross monthly income.
- Income adjustments are also monthly.
- All income and adjustments require supporting documentation.

63

63

ELIGIBILITY ASSESSMENT

Income Changes - continued

The Program will now ask information about current tax filings and require copies of those tax filings, in the situations below.

- During eligibility determination and Premium Assistance is requested.
- Part of a program participants income or income deductions can only be verified using tax documents.

Failure to provide current tax filings, when applicable, may delay or disrupt your eligibility.

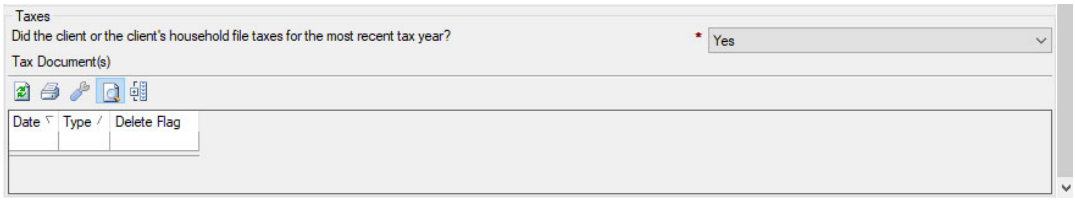
64

64

ELIGIBILITY ASSESSMENT

Income Changes - continued

Below is an example of an applicant whose household filled taxes for the most recent tax year.



65

65

ELIGIBILITY ASSESSMENT

Medical Tab Changes

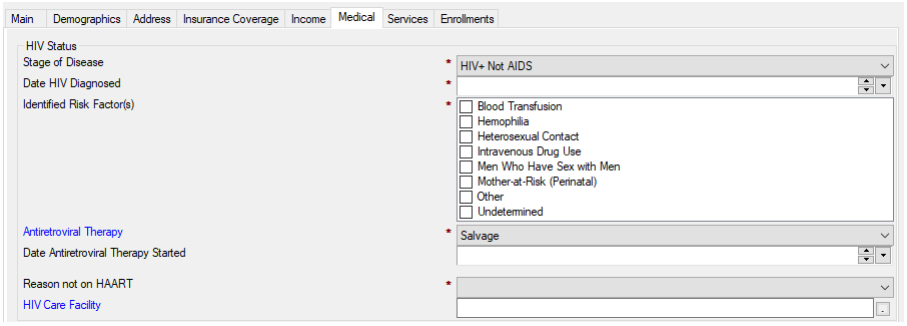
- The Program combined the Medical and Care Team tabs of the Eligibility Assessment and is now only requesting information on the applicants HIV status including proof of HIV and current labs, their current antiretroviral therapy regimen, and what facility the applicant is receiving their HIV care from.
- Knowing where the client is receiving their HIV care from is vital to ensure the Program and your HIV medical care provider can communicate and coordinate your services.

66

66

ELIGIBILITY ASSESSMENT

Medical Tab Changes - continued



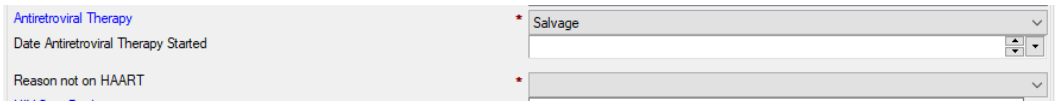
67

67

ELIGIBILITY ASSESSMENT

Medical Tab Changes - continued

The addition of the antiretroviral therapy question to this tab is shown below.



For more information on what the values for this field are, click on this field's blue label. You will be provided a detailed description of each option.

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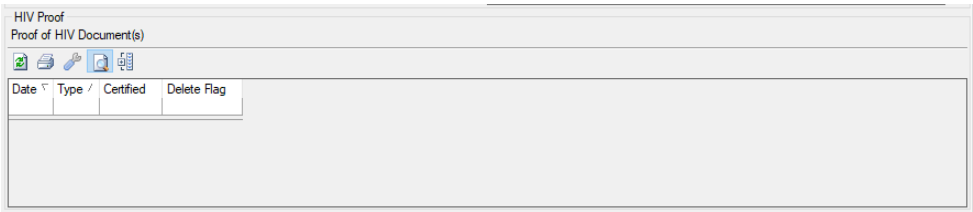
ELIGIBILITY ASSESSMENT

Medical Tab Changes - continued

The Proof of HIV section of this tab will now only show when the applicant does not have a certified proof of HIV on file.

If the applicant already has a certified proof on file, this section will disappear.



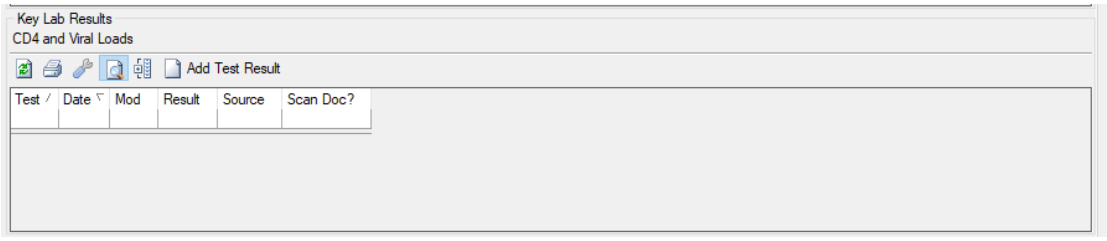
69

69

ELIGIBILITY ASSESSMENT

Medical Tab Changes - continued

The Key Lab Results section remains the same.



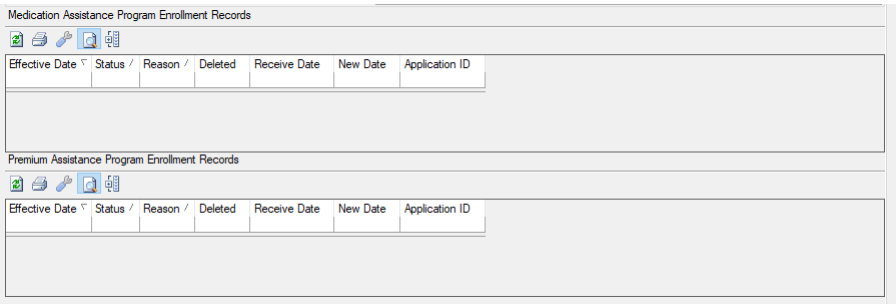
70

70

ELIGIBILITY ASSESSMENT

Services Tab Changes

This tab now contains two new embedded views that contain the program participants enrollment history in both Medication Assistance and Premium Assistance.



71

71

ELIGIBILITY ASSESSMENT

Services Tab Changes

This tab still has the individual fields asking about each set of services.

72

72

QUESTIONS?

73

73

ELIGIBILITY ASSESSMENT

Processing Changes

Due to the changes we have just discussed, there are also some changes to how the assessment is processed.

74

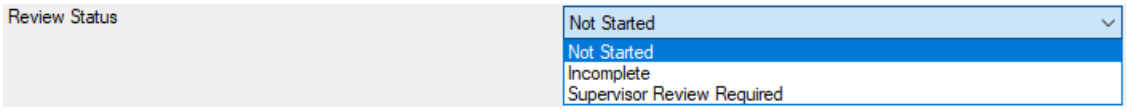
74

ELIGIBILITY ASSESSMENT

Processing Changes – Review Status

You will notice the Review Status field can no longer be manually set to "Complete". This automatically happens when you click on the "Complete" button.

This field can still be manually set to "Incomplete", "Supervisor Review", or "Not Started" by the Department as needed.



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ELIGIBILITY ASSESSMENT

Processing Changes – Documentation

You will notice there is still a question in each documentation section asking if the attached documentation is sufficient. You are still required to review the documents and answer these questions.

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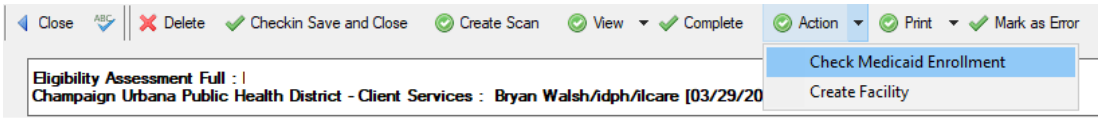
ELIGIBILITY ASSESSMENT

Processing Changes – Checking Medicaid

You are still required to issue a Medicaid check before you process the assessment. You can issue this check from the Action button within the assessment.



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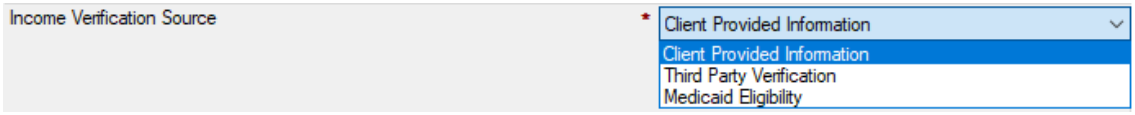
ELIGIBILITY ASSESSMENT

Processing Changes – Verifying Income

When verifying household income, you now have a field to document what information was used. Your options are shown below.



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ELIGIBILITY ASSESSMENT

Processing Changes – Verifying Income

- Client Provided Information is used when you are using the documentation uploaded with the assessment.
- Third Party Verification is used if you are using income information from a trusted third party like the IRS database or the income verification system from DHS.
- Medicaid Eligibility is selected if the client is verified as having Medicaid insurance coverage. By having this coverage, another state program has already verified the clients income.

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ELIGIBILITY ASSESSMENT

Processing Changes – Authorizing Services

- You will notice there are no more questions asking you to authorize services. Once you click the "Complete" button, the new assessment will automatically determine eligibility and determine if services will be authorized based on the Program's established eligibility criteria.
- The system will inform you of these determinations via pop-up messages displayed on your screen.
- These pop-ups will tell you what the system has determined and if the determination makes the applicant not eligible or will grant a conditional approval, the message will tell you why.

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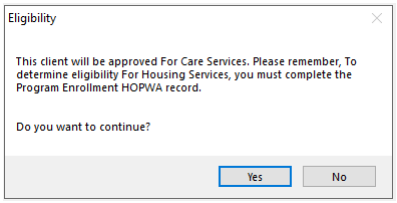
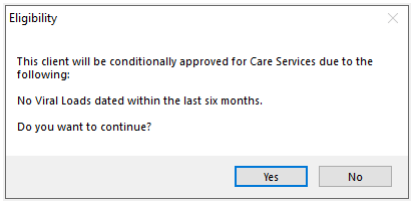
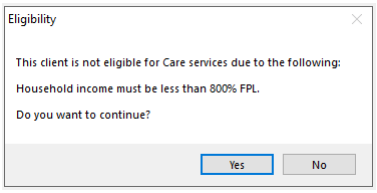
ELIGIBILITY ASSESSMENT

Processing Changes – Authorizing Services – Care Services

The screenshots below show you how the messages will look for Care Services.







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ELIGIBILITY ASSESSMENT

Processing Changes – Authorizing Services

- Only once the message presented has been acknowledged by clicking the “OK” button, will the system create the necessary updates and enrollment records.
- If you click on the “Cancel” button, the system will stop processing the assessment allowing you to determine your next steps.

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QUESTIONS?

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CLIENT PROFILE

- In conjunction with the changes made to the Eligibility Assessment, the Client Profile has had similar updates to ensure both records look and feel similar.
- The following slides outline these changes.

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CLIENT PROFILE

Demo Tab

- The Program has removed the Household tab and moved the information on this tab to the Demo tab. This was done to consolidate all the information needed to determine household size to the same tab.
- In response to the Data Governance and Organization to Support Equity and Racial Justice Act (20 ILCS 65), the Program has also added two new questions to this tab.
- These questions ask about preferred pronouns, being a descendent of people who inhabited the Americas prior to European colonization and about having a disability.

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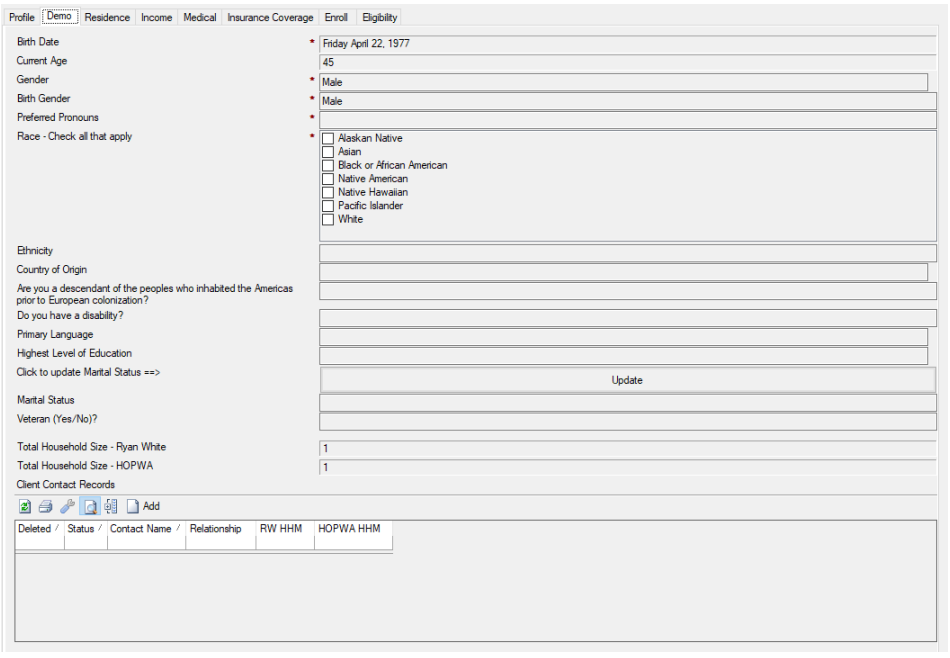

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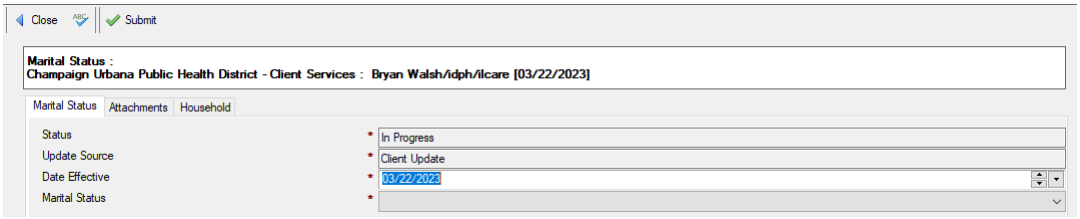
CLIENT PROFILE

Demo Tab – Marital Status Update

Marial Status changes are now controlled through the “Update” button above the Marital Status field. Clicking this button will create a new Marital Status Update record. This record allows you to change the program participants marital status.



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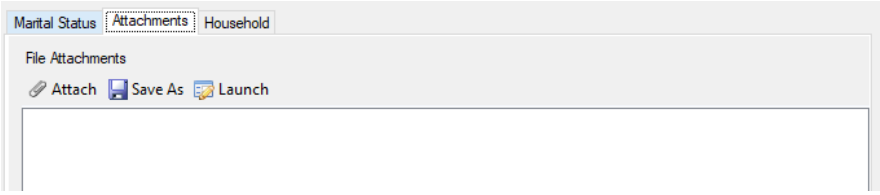
CLIENT PROFILE

Demo Tab – Marital Status Update

Upon any change of marital status, the documentation tab allows you to upload supporting documentation. This is required in some instances such as changing the status to legal separation.



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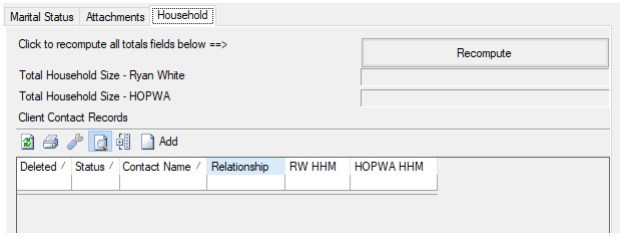
CLIENT PROFILE

Demo Tab – Marital Status Update

The Household tab on this record allows you see the program participant's documented household members and allows you to make any necessary changes to these records while you are updating the marital status records.



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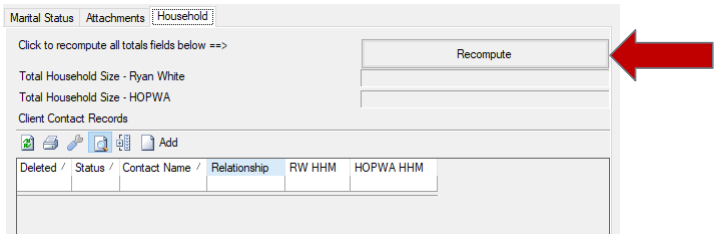
CLIENT PROFILE

Demo Tab – Marital Status Update

When all changes to household members have been completed, you must click on the Recompute button to update the household size fields.



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CLIENT PROFILE

Demo Tab – Marital Status Update

- The process flow of this record works the same way as the Address Update and Income Update records.
- Once submitted, if the client is enrolled in Medication Assistance, the update will be submitted to IDPH for review and approval.
- If the client is not enrolled in Medication Assistance, the record will be automatically approved and the changes applied.

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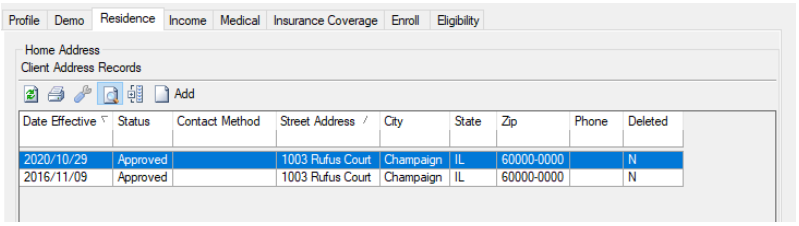
CLIENT PROFILE

Residence Tab

The Residence tab no longer contains the specific information regarding the program participant's address. Instead, this tab contains an embedded view of Address records that have been created.



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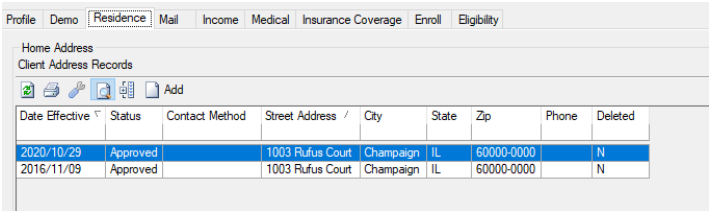
CLIENT PROFILE

Residence Tab - continued



As you can see, this embedded view is in descending order with the most recent record at the top.

To see more detail, you can open any record by double-clicking on it.

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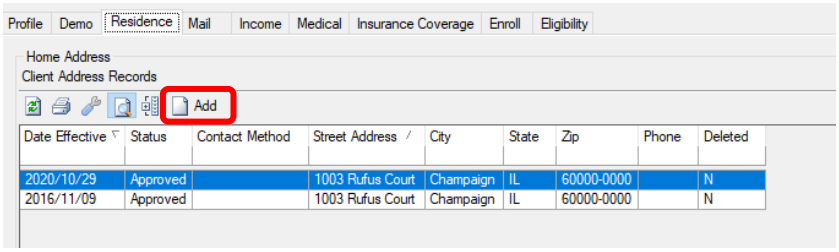
CLIENT PROFILE

Residence Tab - continued

To update this information, you can click on the “Add” button at the top of the view. This will create a new Address Update record.



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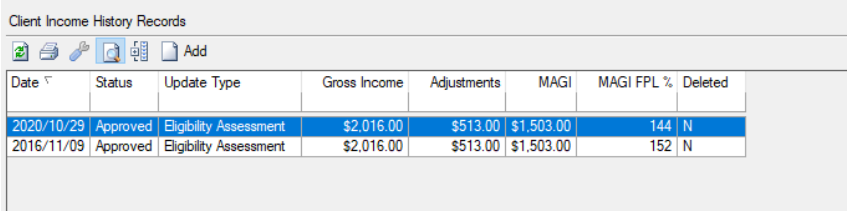
CLIENT PROFILE

Income Tab

The Income tab no longer contains the specific information regarding the program participant's household income. Instead, this tab contains an embedded view of Income records created.



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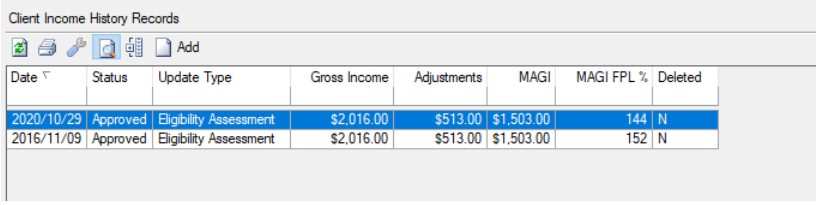
CLIENT PROFILE

Income Tab - continued



This embedded view is in descending order with the most recent record at the top.

To see more detailed income information, you can open any record by double-clicking on it.

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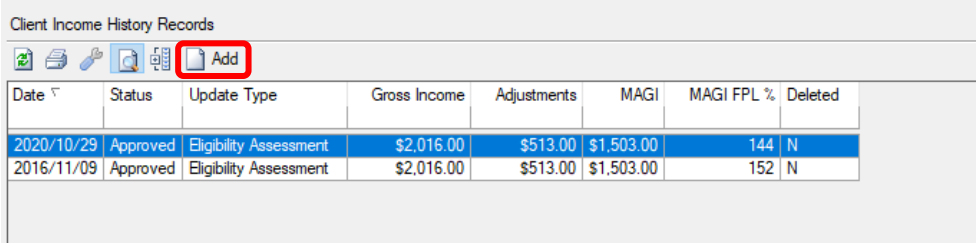
CLIENT PROFILE

Income Tab - continued

To update this information, you can click on the ADD button at the top of the view. This will create a new Income Update record.



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CLIENT PROFILE

Insurance Coverage Tab

- Just like the changes outlined for the Insurance section of the Eligibility Assessment, the Insurance Coverage Tab of the Client Profile will no longer be collecting detailed insurance information such as insurance carrier, plan name, group number, RX Bin, etc.
- This tab will only show simple questions to collect information to determine if the program participant has insurance and what type(s) of insurance do they have.

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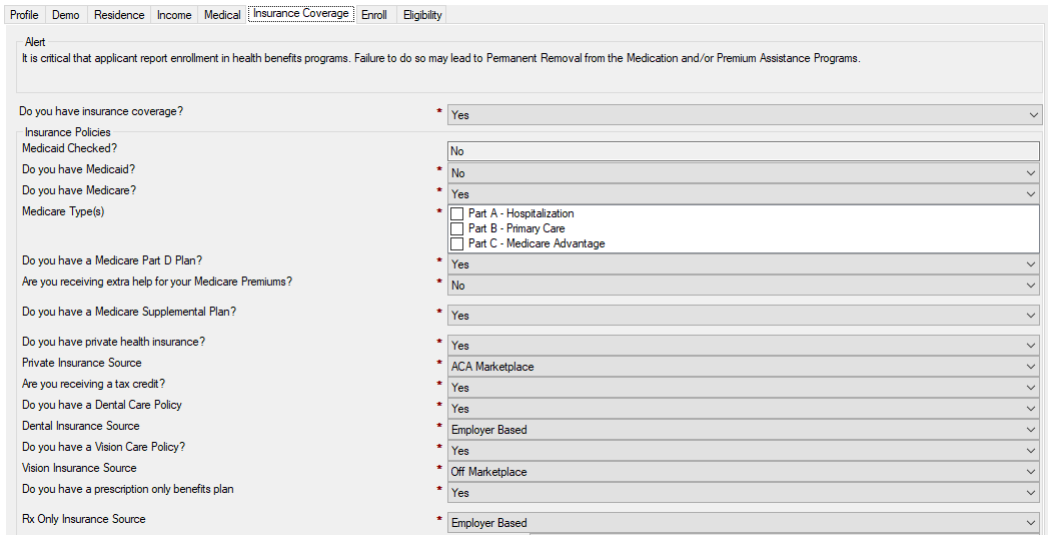

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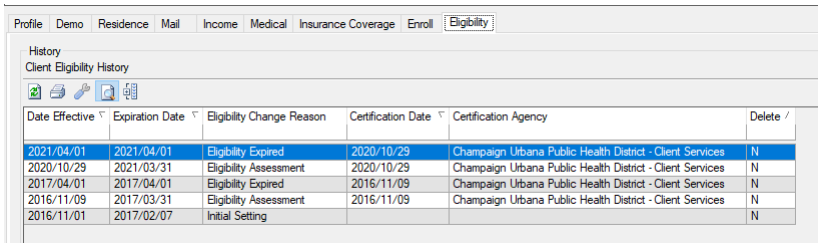
CLIENT PROFILE

Eligibility Tab

The Eligibility tab no longer contains the specific information regarding the program participant's eligibility. Instead, this tab contains an embedded view of Eligibility History records.



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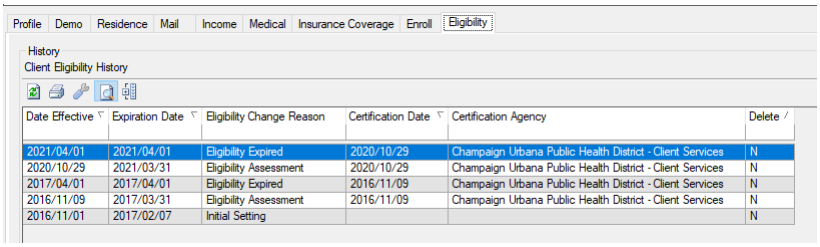
CLIENT PROFILE

Eligibility Tab



Date Effective	Expiration Date	Eligibility Change Reason	Certification Date	Certification Agency	Delete
2021/04/01	2021/04/01	Eligibility Expired	2020/10/29	Champaign Urbana Public Health District - Client Services	N
2020/10/29	2021/03/31	Eligibility Assessment	2020/10/29	Champaign Urbana Public Health District - Client Services	N
2017/04/01	2017/04/01	Eligibility Expired	2016/11/09	Champaign Urbana Public Health District - Client Services	N
2016/11/09	2017/03/31	Eligibility Assessment	2016/11/09	Champaign Urbana Public Health District - Client Services	N
2016/11/01	2017/02/07	Initial Setting			N

This embedded view is in descending order with the most recent record at the top.

To see the detailed eligibility information, you can open the record by double-clicking on it.

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QUESTIONS?

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WHEN?

May 1, 2023

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PREPARATION

For the Program to properly transition to the new Eligibility Assessment and Eligibility Attestation, there will be some deadlines implemented.

- From April 24, 2023 through April 30, 2023, program participants and case managers will NOT be able to submit an Eligibility Assessment.
- The Program will use this time to process any assessment submitted before April 24th. Any assessment that is still incomplete or unable to be fully processed by April 30, 2023 will be denied.
- Any program participants who have an assessment denied during this time will not be able to reapply until May 1, 2023 and will be required to use the new assessment format and new documentation requirements.

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PREPARATION

- For this reason, it is imperative that program participants and case managers make sure all issues are resolved and all missing/invalid documentation, for all assessments submitted prior to April 24, 2023, is provided to the Program so that these assessments can be processed without delay.
- For emergency situations such as individuals who are currently pregnant, under age 18, about to be released from a hospital setting or from a correctional institution, program participants and case managers can contact the Program at:
  - 1-800-825-3518 (M-F 10AM–3PM) for additional guidance.

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RESOURCES

- Regional Lead Agents - https://ilcare.providecm.net
- Training Recordings – http://www.providecm.com/il/Training/CARE/CARE.aspx
- Apply for Services – https://ilcare.providecm.net/home/services
- Client Services Helpline
  1-800-825-3518
  Monday – Friday
  10 AM – 3 PM

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QUESTIONS?

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