THE HEALTH COUNCILS INC.
We Make Health Care Better

REVISED FORM – September 09

ENROLLMENT APPLICATION FOR MEDICARE PART-D ASSISTANCE

INSURANCE SERVICES PROGRAM

Date of Enrollment Request: _____

My client _____ **RWIS #** _____ *residing in zip code* _____ is a **MEDICARE PART-D RECIPIENT** who is requesting assistance for premium or prescription drug co-payment support through the *Insurance Services Program* administered by The Health Councils, Inc. My client meets the following eligibility criteria for program access:

- He/she is HIV+ with symptoms *OR* has AIDS.
- He/she has Medicare Part A, B and D
- He/she does not have a secondary insurance policy providing access to prescription drug benefits

My client is (check one): ☐ **on HIV drug therapy** ☐ **not on HIV drug therapy**

☐ If the RWIS system is in place at the time of this request, I attest that I have submitted my client's original RWIS consent form to The Health Councils, Inc.

CAUTION: Please advise your client that premiums and/or co-payments made using ISP funds do not count toward the 'TrOOP' (or True Out of Pocket costs) that must be incurred by Medicare Part-D recipients in order to become eligible for catastrophic coverage.

CLIENT DEMOGRAPHICS *(please insert numerical codes as specified by Hillsborough County Government)*					
Social Security Number	**Gender**	**Ethnicity**	**Race**	**Income**	**Housing/Living Arrangements**
Medical Insurance	**HIV/AIDS Status**	**Enrollment Status**	**DOB**		**Exposure**

CLIENT INFORMATION							
COUNTY OF RESIDENCE *(check one):*							
	Hardee		Highlands		Manatee		Pinellas
	Hernando		Hillsborough		Pasco		Polk

ESTIMATED ANNUAL SERVICE NEEDS			
HEALTH INSURANCE		**PRESCRIPTION DRUG C0-PAYMENTS**	
Premium Payment Per Month	**$**	Drug Co-Payments Per Month	**$**
x 12 months	12	x Estimated Number of Months Needing Medicare Part-D Assistance	
Estimated Total Premiums	**$**	**Estimated Total Co-Payments**	**$**

Signature below attests that I have had documented contact with my client within the last 60 days, and that I intend to continue to have contact with him/her at least every 60 days to keep him/her eligible for Insurance Services Program services. My signature also attests that – *if the RWIS system is in place on this date* - I have attached a copy my client's RWIS consent form to this application for use by The Health Councils, Inc. My client's co-payment invoice is attached to this initial request for service.

CASE MANAGER'S SIGNATURE **AGENCY** **PHONE #** **FAX #**

PLEASE RETURN BY MAIL OR FAX TO:
The Health Councils, Inc. Attention: Barbara Hay
9600 Koger Boulevard, Suite 221 St. Petersburg, Florida 33702 FAX (727)570-3033