DIRECT DISPENSING RECERTIFICATION

SOUTH CAROLINA DEPARTMENT OF PUBLIC HEALTH

Return to:
Direct Dispensing Program (DDP)
3rd Floor, Mills/Jarrett
Box 101106
Columbia, SC 29211

FOR INTERNAL USE ONLY - DO NOT WRITE IN THIS SPACE
Date Received: _____ Status/Date: _____
Final Status/Date _____
Completed By: _____

Purpose: This form is to recertify for the Direct Dispensing Program (DDP).

I. ENROLLEE INFORMATION **DAP ID:**

Last Name: _____ First Name: _____ Full Middle Name: _____

Month/Year of Birth: ____/XX/_____ Last 4 of SSN: XXX-XX-_____ Gender: _____
Street Address 1: _____ Street Address 2: _____
City: _____ State: _____ Zip code: _____ County: _____
Mailing Address: _____ City: _____ Zip: _____
Home Phone (_____) _____ Other Phone (_____) _____

Ethnicity (check one): o Hispanic/Latino (a): o Mexican o Puerto Rican o Cuban o Other_____
o Non-Hispanic/Latino (a)

Race (check all that apply): o American Indian or Alaskan Native o Black o White
o Asian: o Asian Indian o Chinese o Filipino o Japanese o Korean o Vietnamese
o Other _____
o Native Hawaiian or Other Pacific Islander: o Native Hawaiian o Guamanian or Chamorro
o Samoan o Other Pacific Islander
o Unknown o Other_____

II. ELIGIBILITY INFORMATION (Please attach a separate page for income if more pages are needed for additional household

Enrollee and Other Members in Household	Relationship to Enrollee	Gender	Date of Birth	Place of Employment or Source of Other Income	Estimated **Yearly Gross** Income
Enrollee					

Current Physician: _____ **Current Case Manager:** _____

III. BENEFITS INFORMATION (To be completed by the Case Manager, Nurse, or Physician)

Does the enrollee have Medicaid coverage? o Yes o No Medicaid application pending? o Yes o No
Does the enrollee have Medicare Part D coverage? o Yes o No Medicare Part D application pending? o Yes o No
Does the enrollee have Insurance Coverage for Prescriptions? o Yes o No

IV. CLINICAL INFORMATION (To be completed by the Physician)

Current Disease Stage: o HIV/AIDS Status Unknown o HIV Negative o HIV+, not AIDS
Current Disease Stage: Date of Diagnosis:____ /_____ /_____
Meets the CDC's case definition of AIDS? o Yes o No Date AIDS Diagnosed: _____/_____/_____ o Unknown
The ***most recent*** CD4 (T4) lymphocyte count was _____ on _____/_____/_____(date drawn)
The ***most recent*** viral load result was _____ on _____/_____/_____(date drawn) o Pretreatment? o On therapy?

V. CERTIFICATION/CONSENT

1. I certify that the information provided in this application is true and correct to the best of my knowledge.
2. I agree to notify the SC Drug Assistance Program (DAP) of any changes to my income or Medicare/Medicaid/Insurance status within 30 days. I will inform DAP if my address changes or if I choose not to participate in the program.
3. I understand that refusal to use third party resources and/or other requirements are reasons for closure to further program sponsorship.
4. I also understand the importance of taking medications as prescribed and that failure to do so may result in my being dropped from the program. If applicable, I certify that information provided regarding the number of household members, family income and insurance benefits is true and correct to the best of my knowledge.
5. I give permission to DAP to verify this information, either through written documentation or electronic files.
6. By my signature, I authorize the release of information pertaining to my participation in DAP to other pharmaceutical companies or pharmacies, as needed. I further authorize the release of information pertaining to my participation in DAP for the purpose of payment or clinical treatment review to the organization(s) associated with the referring physician, referring case manager, and/or case manager if not the referring case manager indicated below.
7. By my signature below as enrollee, parent, or guardian, I request that payment of Medicare/Medicaid or other third party insurance benefits be made on my behalf to the SC Department of Public Health (DPH) for any services, including services related to this application, that are provided to me.
8. Permission is also granted to DPH to exchange the medical or other confidential information as necessary to the Centers for Medicare and Medicaid Services (CMS), its agents or other agents needed to determine benefits for related services.
9. I understand that in order to receive services, correspondence will be sent to the address provided.

_____ _____
Enrollee's Signature Date

Referring Physician or Case Manager (Print Name)	Signature	Date	Organization (Print)	Phone

Case Manager if NOT the Referring Case Manager (Print Name)	Signature	Date	Organization (Print)	Phone

DIRECT DISPENSING PROGRAM (DDP) RECERTIFICATION

Instructions for Completing 1541-ENG-DPH

Purpose: This form will be used to provide relevant information to recertify enrollees for the Direct Dispensing Program (DDP).

Important: This form must be completed and signed by the enrollee AND the enrollee's physician or case manager. All supporting documentation (including income documentation) must be submitted with the form.

Instructions:

I. Enrollee Information

DAP ID: Enter the enrollee's DAP ID, if available.
Name: Enter the enrollee's last, first, and full middle name.
Date of Birth: Enter the enrollee's month and year of birth.
Social Security Number: Enter the last 4 digits of the enrollee's social security number.
Gender: Enter the enrollee's gender (Male, Female, or Transgender).
If the last 4 of the Social Security # is not provided, indicate if the enrollee has lived in SC for at least 3 months.
Home Address: Enter the street address where the enrollee lives. Do not enter a PO Box.
County: Enter the county name where the enrollee lives.
Mailing Address: If different from the street address, enter the address (Street or PO Box #) where the enrollee wants to receive medications and other correspondence. *NOTE:* You must notify DAP immediately if there is a change in the mailing address.
Telephone: Enter the area code and telephone number where the enrollee can be reached. Please list both home and work numbers, if possible. *NOTE:* You must notify DAP immediately if there is a change in the telephone number.
Ethnicity: Enter the enrollee's ethnicity.
Race: Enter the enrollee's race.

II. Eligibility Information

Financial Data: List the following in the table:
Place of employment, estimated yearly income of the enrollee.
Other members of the household, relationship to the enrollee, gender, date of birth, place of employment or source of income. Write "unemployed" if not working - do not write N/A, do not leave blank and do not draw a line through the space.
Proof of income is required for the enrollee and for each member of the household listed on the form.
NOTE: The Eligibility Information section is important and must be completed or the form will be returned. Please enter all of the information including a complete list of the household dependents and their individual income documentation (this may be useful in determining if the enrollee still qualifies for the program).
Current Physician/Current Case Manager: Enter the name of the enrollee's physician and case manager.

III. Benefits Information (This section should be completed by the Case Manager, Nurse, or Physician)

Medicaid coverage: Check the appropriate box if the enrollee has Medicaid coverage.
Medicaid application pending: Check the appropriate box if the enrollee's Medicaid application is pending.
Medicare Part D coverage: Check the appropriate box if the enrollee has Medicare Part D coverage.
Medicare Part D application pending: Check the appropriate box if the enrollee has an application pending for Medicare Part D coverage.
Insurance coverage: Check the appropriate box if the enrollee has private or commercial insurance that covers prescription drugs.

IV. Clinical Information (This section should be completed by the physician)

Current Disease Stage: Check the appropriate box for the current disease stage.

Date of HIV diagnosis: Enter the date of HIV diagnosis.

Meets the CDC's case definition of AIDS?: Check Yes or No. If Yes, enter the date of AIDS diagnosis or select Unknown if date of AIDS diagnosis is unknown.

CD4 count: Enter the most recent CD4 count and the date the blood was drawn.

Viral load: Enter the most recent Viral Load information and the date the blood was drawn.

V. Certification/Consent

Consent: This section is mandatory. The enrollee must read and understand the conditions for continued enrollment in the program and sign on the line *"Enrollee's Signature"* and date the form.

Referring physician or case manager: The referring physician or case manager must sign and date this section. The organization name must be printed clearly. The referring case manager is typically the enrollee's nurse or social worker who actively monitors the enrollee's clinical progress and treatment adherence.

Case manager if not the referring case manager: This section is to be completed if the enrollee has a case manager who's different from the referring case manager. The case manager should sign and date this section. The organization name must be printed clearly. This case manager is usually a nurse or social worker who assists the enrollee with completing the recertification form. In some instances, the recertification form will be forwarded to another nurse or social worker who actively monitors the enrollee's clinical progress and treatment adherence.

Office Mechanics

Protected Health Information: This form contains Protected Health Information (PHI) and should be stored and/or disposed in accordance with your organization's privacy policy. Appropriate forms of storage include but are not limited to: 1) in imaged format and secured in your electronic health record (EHR) system, 2) in paper format in each enrollee's secure chart/file, 3) shredded in accordance with your organization's privacy policy. This record of disclosure must remain available for a six (6) year retention period.

Completed recertification forms must be submitted into Provide Enterprise by the enrollee's Case Manager or mailed to:

Direct Dispensing Program
3rd Floor, Mills/Jarrett
Box 101106
Columbia, SC 29211