SC ADAP WAITLIST ANNUAL UPDATE FORM

D H E C
PROMOTE PROTECT PROSPER

Return to:
Direct Dispensing Program
PO Box 809
State Park, SC 29147
PH: (803) 896-6250 or (800) 856-9954
FAX: (803) 896-5310

FOR ADAP USE ONLY - DO NOT WRITE IN THIS SPACE
Date Received: _____
Status : _____
Status/Date : _____

Instructions: This form is to be filled out by clients who have been placed on the SC ADAP waitlist after 03/15/2010

I. PATIENT INFORMATION

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

Date of Birth: _____/_____/_____ Social Security #: _____- _____ - _____

Street Address 1_____ Street Address 2 _____

City _____ State _____ Zip Code _____ County _____

Mailing Address: _____ City: _____ Zip: _____

Home Phone: (_____) _____ Other Phone (_____) _____

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

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

Acceptable documentation of income:most recent pay stubs, W2 forms, Federal Tax Return, Pensions, Unemployment Compensation statement, Social Security benefits, Alimony, Child Support, Worker's Compensation, Wage Statement (obtained from the local unemployment office if you do not have any income).

Do you have medical insurance? ☐ Yes ☐ No Do you have Medicare coverage? ☐ Yes ☐ No

Do you have Medicaid coverage? ☐ Yes ☐ No Medicaid application pending? ☐ Yes ☐ No

Are you currently enrolled in a Pharmaceutical Assistance Program (PAP)? ☐ Yes ☐ No

Are you currently taking medications? ☐ Yes ☐ No, if yes, please list: _____

III. CERTIFICATION/CONSENT

I certify that the information provided in this application is true and correct to the best of my knowledge. I give permission to ADAP to verify this information, either through written documentation or electronic files. I agree to notify ADAP of any changes to my income or Medicaid/insurance status within 30 days. I will inform ADAP if my address changes or if I choose not to participate in the program. I understand that refusal to use third party resources and/or other requirements are reasons for closure to further program sponsorship. I also understand the importance of taking medications as prescribed and that failure to do so may result in my being automatically dropped from the program after 90 days. By my signature, I authorize the release of information pertaining to my participation in ADAP to other pharmaceutical companies or pharmacies, as needed. I further authorize the release of information pertaining to my participation in ADAP for the purpose of payment and to the organization(s) associated with the referring physician, referring case manager, and/or case manager if not the referring case manager indicated on the next page. By my signature below as parent, guardian or client, I request that payment of Medicare/Medicaid or other third party insurance benefits be made on my behalf to the South Carolina Department of Health and Environmental Control for any services, including STD and/or HIV, provided to me. Permission is also granted to DHEC 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 these benefits for related services. 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.

_____ _____
Applicant's Signature Date

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

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

Dear Sir/Madam:

This is a **new SC ADAP waitlist update form.** Our records indicate that you are on the SC Drug Assistance Program waitlist. You are requested to complete the form and submit it via fax or mail in order to remain eligible for the program. Please note the following:

- You must complete this form and return it within **90 days.**
- **YOU MUST SHOW THIS FORM TO YOUR DOCTOR OR CASE MANAGER**. Their signature(s) is/are required to complete this form.
- You must include proof of income.

  Acceptable documentation of income: most recent pay stubs, W2 forms, Federal Tax Return, Pensions, Unemployment Compensation statement, Social Security benefits, Alimony, Child Support, and Worker's Compensation. Please submit a wage statement (obtained from the local unemployment office) if you, or your spouse, do not have any income (zero income).

The *Eligibility Information* section is important and must be completed or the form will be returned to you. Please enter all of the information including:-

- Place of employment or source of income
- The income amount you receive (weekly, bi-weekly, monthly, or yearly)
- A list of all of your household dependents and their income documentation (this may be useful in determining if you still qualify for the program)

Do NOT leave the eligibility information section blank. You must provide the income documentation with this recertification form to remain on the waitlist.

YOU WILL BE REMOVED FROM THE WAITLIST IF YOU DO NOT SUBMIT THIS FORM.

If you have any questions, please contact us at 1(800) 856-9954, or you may contact your case manager, nurse, or doctor.

Sincerely,
Direct Dispensing Program Staff
PO Box 809
State Park, SC 29147
PH: (803) 896-6250 or (800) 856-9954
FAX: (803) 896-5310

SC ADAP Waitlist Annual Update Form (DHEC 1516)
Instructions

Purpose: This form will be used to determine the client's eligibility to remain on the SC ADAP waitlist beyond a period of one year.

Important:

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

Instructions:

I Patient information

Name: Enter the applicant's last, first, and full middle name.

Date of Birth: Enter the month, day, and year of the applicant's birth.

Social Security Number:
Enter the applicant's social security number. Contact the SC ADAP staff if the applicant does not have a social security number.

Home Address: Enter the street address where applicant lives. Do not enter a PO Box.

County: Enter the county name where the applicant lives.

Mailing Address:
If different from the street address, enter the address (Street or PO Box #) where the applicant wants to receive medications and other correspondence. *NOTE*: You must notify SC ADAP immediately if there is a change in the mailing address.

Telephone:
Enter the area code and telephone number where the applicant can be reached. Please list both home and work numbers, if possible. *NOTE*: You must notify SC ADAP immediately if there is a change in the telephone number.

II Eligibility Information

Financial Data: List the following in the table:-

- Place of employment, estimated yearly income of the applicant
- Other members of the household, relationship to the applicant, 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 applicant and for each member of the household listed in the application.

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 applicant still qualifies for the program)

Medical insurance: Check the appropriate box if the applicant has (yes) or does not have (no) medical insurance

Medicare coverage: Check the appropriate box if the applicant has (yes) or does not have (no) Medicare coverage.

Medicaid coverage: Check the appropriate box if the applicant has (yes) or does not have (no) Medicaid coverage.

Medicaid applicant pending: Check the appropriate box if the applicant has Medicaid coverage pending (yes) or not pending (no)

Pharmaceutical Assistance Program:
Check the appropriate box if the applicant is enrolled in and receiving medications through a pharmaceutical assistance program

Medications:
Check the appropriate box if the applicant is receiving (yes) or not receiving (no) medications. If yes, list the medications the applicant is taking.

III Certification and Consent

Consent:
This section is compulsory. The applicant must read and understand the conditions for acceptance into the program and sign on the line "*Applicant's Signature*" and date the application.

Referring physician or case manager:

The referring physician or case manager (*see below for definitions of case manager and referring case manager*) must sign and date this section. The organization name must be printed clearly.

Case manager if not the referring case manager:

This section is to be completed if the applicant has a case manager who different from the referring case manager (*see below for definitions of case manager and referring case manager*). The case manager should sign and date this section. The organization name must be printed clearly.

Definitions:

Referring Case Manager:

The referring case manager is typically the applicant's nurse or social worker who actively monitors the patient's clinical progress and treatment adherence.

Case Manager if not the Referring Case Manager:

This case manager is usually a nurse or social worker who assists the patient with completing the application. In some instances, the application will be forwarded to another nurse or social worker who actively monitors the patient's clinical progress and treatment adherence. This person is referred to as the '*case manager if not the referring case manager'*.

Completed applications must be mailed to:

Direct Dispensing Program
PO Box 809
State Park, SC 29147

OR

Faxed to: 803-896-5310