

State of New Hampshire

Department of Health and Human Services, Division of Public Health Services

29 Hazen Drive, NH 03301-6504

Tel. 603-271-4480 or 1-800-852-3345, Ext. 4480 TDD Relay Access: 1-800-735-2964 FAX: (603) 271-4934.

NH CARE Program Financial Need Statement

Please check all the programs for which you are requesting assistance:

- DRUG ASSISTANCE, INSURANCE CONTINUATION, (HCBC)HOME AND COMMUNITY BASED CARE, CASE MANAGEMENT, PRIMARY CARE

Personal Information

Form with fields for Last Name, First Name, M.I., Mailing Address, City/Town, State, Zip, Phone, and E-mail.

Date of Application: [ ] Is this a Re-enrollment? [ ]Yes [ ]No

Large form with multiple sections: Social Security Number, Gender, Residency, Date of Birth, Contact preferences, Case manager, Primary and specialty care providers, Pharmacy, Hospitalization, Housing status, and Mother's name.

Revised 06/07

## Civil Rights Survey

We are gathering this information to make sure that our services are available to everyone without discrimination. Your answers will be kept confidential.

What language do you speak most often?  English  Spanish  French   
 Other \_\_\_\_\_

Which of the following best describes your race?

- White  Black or African American  Asian  Native Hawaiian/Pacific Islander  
 American Indian/Alaskan Native  More than one race

Which of the following best describes your ethnicity? Country of birth: \_\_\_\_\_

- Hispanic or Latino/a  Non-Hispanic or Non-Latino/a

## Health Insurance Coverage

➔	Is this a Medicare Part D Plan? Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Note: If you are currently covered by health insurance or have access to health insurance, this program is designed to assist you with premium payments, deductibles and co-pays. The program is also designed to assist you with payments for you to continue coverage with COBRA. This is done through the Insurance Continuation Program and does not disclose status or confidential information. Please contact a program representative for more information.	
➔	Are you eligible for insurance or medical care through:	
	<input type="checkbox"/> Employer <input type="checkbox"/> COBRA <input type="checkbox"/> School <input type="checkbox"/> Veteran's Administration <input type="checkbox"/> Spouse's/Partner's Employer <input type="checkbox"/> Self-Employed <input type="checkbox"/> Not eligible	
➔	Are you covered by any group or individual health insurance?	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	
➔	Does that insurance cover the cost of prescription drugs?	
	<input type="checkbox"/> Yes <input type="checkbox"/> Partial <input type="checkbox"/> No	
➔	If partial coverage, do you have a co-pay or a deductible?	
	<input type="checkbox"/> Yes \$_____ Generic \$_____ Brand Name <input type="checkbox"/> No Co-pay	
➔	If partial coverage, do you have a cap or a limit on your prescription coverage?	
	<input type="checkbox"/> Yes \$_____ /Year Cap <input type="checkbox"/> No Cap	
➔	Insurance company or Insurance program name:	
➔	Insurer Telephone Number:	Policy/Certificate Number:
		Group Number:
➔	If insurance is from your employer or COBRA, who do we contact to pay premiums (personnel, etc.)? Contact name / Telephone Number:	

Revised 06/07

## Medicaid / Medicare Information

➔	Are you covered by Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	District Office:	Medicaid ID Number:
➔	Have you applied for Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No	➔ If Yes, what was the date of application?
➔	Have you been denied? <input type="checkbox"/> Yes <input type="checkbox"/> No	➔ If Yes, what was the reason for the denial?
<b>Note: In order to be enrolled in the NH CARE Program you must submit a complete application to the NH Medicaid Program</b>		
➔	Are you covered by Medicare Part A? <input type="checkbox"/> Yes <input type="checkbox"/> No	
➔	Are you covered by Medicare Part B? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Are you covered by Medicare Part D? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	➔ If Yes, when were you first covered by Medicare Part B? _____ Medicare Part D? _____ (Persons who have become eligible for Medicare Part B within the last 6 months may be eligible for supplemental insurance. Medicare Part D enrollees may be eligible for copay assistance)	
➔	If yes, Medicare Claim Number:	

## Income Information

➔	What is your household size?:	(for example, yourself plus the number of dependents you put on your income tax return)
➔	What's your gross annual household income?: \$	

Ⓢ This means total income before deductions such as income tax and Social Security. Include the wages of all working household members and benefits like Social Security payments, pensions, unemployment insurance payments, and other types of income. Fill in gross wages of salary for whichever time period is most appropriate.

	Gross Salary & Wages	& Other Sources of Income (such as Alimony, unemployment insurance, pensions, Social Security)
Weekly or	\$ _____	\$ _____
Monthly or	\$ _____	\$ _____
Yearly	\$ _____	\$ _____

Other Financial supports:    Spouse    Significant Other    Family members  
 Roommate    Savings/ Investments  
 Other:

**➔ Attach a copy of any one of the following:**

Please Note: If this is not attached it can significantly delay your authorization!

<div style="border: 2px solid black; width: 40px; height: 40px; margin-bottom: 5px;"></div> Your most recent Federal Income Tax Form 1040; or <div style="border: 2px solid black; width: 40px; height: 40px; margin-bottom: 5px;"></div> Your most recent pay stub; or	<div style="border: 2px solid black; width: 40px; height: 40px; margin-bottom: 5px;"></div> A letter from your employer indicating your salary; or <div style="border: 2px solid black; width: 40px; height: 40px; margin-bottom: 5px;"></div> A photocopy of an alimony, unemployment insurance, pension and/or Social Security check; or
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Note: Complete the following only if your income exceeds the guideline on the information sheet

➔ Medical Expenses: \$ \_\_\_\_\_

In the last 12-months, what were your total out-of-pocket household medical expenses (those not covered by Medicaid, medical insurance or any other third-party payor)? Include any insurance premiums, as well as those expenses that you have already paid and those you have not yet paid. You must submit receipts for medical expenses in order for the NH CARE Program to allow these deductions for spend down..

# Nondiscrimination Notice, Client Certification, Grievance Procedure

## NONDISCRIMINATION NOTICE

The State of New Hampshire, Department of Health and Human Services does not discriminate against people because of their race, creed, color, sex, sexual orientation, age, political affiliation or beliefs, religion, national origin, or handicap or disability. There will be no discrimination in accepting or providing services, or the admission or access to, or treatment or employment in any of the Department's programs or activities.

The Controller is responsible for coordinating the civil rights compliance efforts of the Department, component offices and divisions to follow state and federal rules against discrimination. For more information, or to learn how to make a discrimination complaint, contact the Controller at 129 Pleasant Street, Concord, New Hampshire 03301-3852 (Telephone: (603) 271-4688 [voice] or the TDD Access number: 1-800-735-2964

The New Hampshire Department of Health and Human Services is subject to Title VI of the Civil Rights Act of 1964 (42 U.S.C. Section 2000d et. seq.); Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. Section 794); Title IX of the Education Amendments of 1972 (20 U.S.C. Section 1681); the Age Discrimination Act of 1975 (ADA) (42 U.S.C. Section 6101 et. seq.); NH RSA 354-A; and certain Federal block grant statutes, including, but not limited to 42 U.S.C. Sections 300w-7, 300x-7 and 708, or any other provision through which the Department receives federal financial participation in its programs. These laws prohibit discrimination on the basis of race, color, national origin, handicap, age, sex, sexual orientation, and religion in Federally-assisted programs and activities. The U.S. Department of Health and Human Services' regulations under Title VI, Section 504, Title IX and the Age Discrimination Act are found at 45 C.F.R., Parts 80, 84, 86 and 91, respectively. The New Hampshire Department of Health and Human Services is further subject to the American with Disabilities Act of 1990 (42 U.S.C., Section 12101, et. seq.) and its implementing regulations at 28 C.F.R., Part 35.

## CLIENT CERTIFICATION

### *By signing below:*

1. I hereby declare that these financial statements are correct and true to the best of my knowledge. I realize that the NH CARE Program receives its funds from the Federal Government and that any intentional misrepresentation may result in legal action against me on the basis of Federal laws. Furthermore, I understand that I will be denied participation if I withhold information, provide inaccurate information, or refuse to provide all of the necessary information. **I agree to notify the NH CARE Program within 30-days of any change in my name, address, eligibility, financial, insurance status or household size**, and to provide evidence of income and medical expenses, Medicaid or Medicare status, health insurance policy if requested to do so by the NH CARE Program. I have read and consent in full to the above and agree to comply with the conditions stated above.

2. In order to be considered for participation in the NH CARE Program, I hereby authorize my physician or his/her representative to release information requested by the N.H. Department of Health and Human Services' Division of Public Health Services NH CARE Program relative to the content of my medical record. I understand that this information will be maintained under strict conditions of confidentiality and that my identity will not be revealed to any persons outside of the N.H. Department of Health and Human Services. All information supplied to the Department of Health and Human Services NH CARE Program is strictly confidential and will only be used for my ultimate benefit.

3. I hereby authorize the staff of the New Hampshire Department of Health and Human Services' NH CARE Program to communicate with and release information, including my diagnosis, to appropriate physicians and other health care professionals including my pharmacist, case manager and other treatment providers, to ensure the best possible planning and delivery of services on my behalf. If I am applying for Insurance continuation, I authorize the NH CARE Program to speak with my employer and/or insurance or COBRA company about my insurance status. The NH CARE Program may contact any third party payors/administrators to ensure coverage and resolve billing issues.

These releases are valid for one year from date of signature unless revoked by me in writing.

Signature of Applicant / Guardian	Date	Signature of Witness	Date
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Revised 06/07

**GRIEVANCE PROCEDURE**

**By signing below you also certify that you have read and understood the following Grievance Procedure.**

1. If you are dissatisfied with any eligibility determination, you may request, within 30 days of the date of the NH CARE Program’s notification letter, an informal case review conference.
2. The NH CARE Program shall notify you within 14 days after the case review conference whether the NH CARE Program concurs, modifies, or revokes the determination.
3. If you or your guardian is dissatisfied with the result of the case review conference, you may request, within 30 days of notification of the results of the case review conference, an adjudicative proceeding which shall be held in accordance with RSA 541-A.
4. You may contact the Office of Ombudsman at any point in the process for neutral resolution of your complaint. 1-800-852-3345, extension 6941.

Please note the first person to contact if you are denied eligibility is the NH CARE Program Manager. If you are dissatisfied with the response you receive from the NH CARE Program Manager, you can contact the Section Director at 1-800-852-3345, extension 4481.

<b>Signature of Applicant / Guardian</b>	<b>Date</b>	<b>Signature of Witness</b>	<b>Date</b>
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**FOR ALL APPLICANTS**

I hereby authorize the staff of the New Hampshire Department of Health and Human Services and/or the City of Boston/ Trustees of Health and Hospitals, which provides funding for this program, access to and review of my client record. The purposes of review are for monitoring only. The review may include information such as name, HIV status, and related diagnoses, substance abuse treatment, medical care and treatment, financial circumstances, living arrangements, and other information as requested. I understand that the review will be visual only, that no records will be copied and no information identifying me will be recorded. This authorization for release of information is for visual review only and in no way authorizes the NH Dept. of Health and Human Services and/or the City of Boston/Trustees of Health and Hospitals the right to remove information or collect personal identifiers. This authorization will have a duration of two years from the date of signing below. I understand I am not required by law to consent to release this information but choose to do so willingly and voluntarily. I understand I may revoke consent at anytime except to the extent action has been taken in reliance of my consent.

<b>Signature of Applicant / Guardian</b>	<b>Date</b>	<b>Signature of Witness</b>	<b>Date</b>
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**Dear Applicant:**

**Please read and sign the release below. Please fill in your doctor's name and address or have your doctor fill out the physician information portion along with pages 7 & 8.**

**Authorization for Release of Information**

In order to be considered for participation in the NH CARE Program, I hereby authorize my physician or his/her representative to release information requested by the NH Department of Health and Human Services' Division of Public Health Services NH CARE Program relative to the content of my medical record. I understand that this information will be maintained under strict conditions of confidentiality and that my identity will not be revealed to any persons outside of the NH Department of Health and Human Services.

All information supplied to the Department of Health and Human Services NH CARE Program is strictly confidential and will only be used for my ultimate benefit. This release is valid for one year from date of signature unless revoked by me in writing.

**Signature of Applicant / Guardian**

**Date**

**Signature of Witness**

**Date**

*Applicant (Print name) →*

**PHYSICIAN INFORMATION**

\_\_\_\_\_

Physician Name

\_\_\_\_\_

Mailing Address

\_\_\_\_\_ ( )

City/Town

State

Zip

Phone

\_\_\_\_\_ ( )

Fax

**New Hampshire Department of Health and Human Services NH CARE Program  
Patient Medical Information To be completed by Physician Only**

Patient Last Name	Patient First Name	M.I.	D.O.B.

**Instructions:** The information on this form is necessary to determine your patient’s medical eligibility for the NH CARE Program. All information on this form, or given over the phone, will be kept strictly confidential by the Department of Health and Human Services. Personal identifying information is never released.

Please complete and return to: the Case Manager and fax or mail to the NH CARE Program, NH Department of Health and Human Services, 29 Hazen Drive, Concord NH 03301-6504 FAX: (603) 271-4934 Tel: (603) 271-4480

**The NH CARE Program has instituted medical eligibility criteria for its AIDS Drug Assistance Program (ADAP). Therefore, the information requested below must be submitted to the NH CARE Program before any drug reimbursement will be authorized. Please note that The NH CARE Program will no longer send one-month authorizations to pharmacies prior to its receipt of medical information.**

To be eligible for prescription drug reimbursement the person:

- 1) Must have had at least one CD4 count of **250 or less** OR
- 2) Is currently on antiretroviral therapy OR
- 3) Currently has an opportunistic infection (OI) among those listed below.

**Opportunistic Infections** Please check all that apply.

<input type="checkbox"/> Candidiasis, bronchi, trachea, or lungs	<input type="checkbox"/> Lymphoma, Burkitt’s (or equivalent term)
<input type="checkbox"/> Candidiasis, esophageal	<input type="checkbox"/> Lymphoma, immunoblastic (or equivalent term)
<input type="checkbox"/> Carcinoma, invasive cervical	<input type="checkbox"/> Lymphoma, primary in brain
<input type="checkbox"/> Coccidioidomycosis, disseminated or extrapulmonary	<input type="checkbox"/> <i>Mycobacterium avium</i> complex or <i>M.kansasii</i> , disseminated or extrapulmonary
<input type="checkbox"/> Cryptococcosis, extrapulmonary	<input type="checkbox"/> <i>M. tuberculosis</i> , pulmonary
<input type="checkbox"/> Cryptosporidiosis, chronic intestinal	<input type="checkbox"/> <i>M. tuberculosis</i> , disseminated or extrapulmonary
<input type="checkbox"/> Cytomegalovirus disease (other than in liver, spleen, or nodes)	<input type="checkbox"/> <i>Mycobacterium</i> , of other species or unidentified species, disseminated or extrapulmonary
<input type="checkbox"/> Cytomegalovirus retinitis	<input type="checkbox"/> Pneumocystis carinii pneumonia
<input type="checkbox"/> HIV encephalopathy	<input type="checkbox"/> Progressive multifocal leukoencephalopathy
<input type="checkbox"/> Herpes simplex: chronic ulcer(s); or bronchitis, pneumonitis or esophagitis	<input type="checkbox"/> Salmonella septicemia, recurrent
<input type="checkbox"/> Histoplasmosis, disseminated or extrapulmonary	<input type="checkbox"/> Toxoplasmosis of brain
<input type="checkbox"/> Isosporiasis, chronic intestinal	<input type="checkbox"/> Wasting syndrome due to HIV
<input type="checkbox"/> Kaposi’s sarcoma	

**Laboratory Values**

<b>Lowest known CD4 count :</b>	<b>cells</b>	<b>%</b>	<b>Month/year:</b>
Client’s most recent outpatient visit:	<b>Month/year:</b>		
Most recent CD4 count :	cells	%	Month/year:
Most recent HIV viral load:	copies/ml		Month/year: Type *:

\* ❶ = bDNA (Chiron Quantiplex (UW lab) undetectable at or below 500 copies); ❷ = RNA-PCR (Roche, PCR, RT-PCR (Swedish) undetectable at or below 400 copies); ❸ = NASBA (Organon Teknika, RNA-QT)  
❹ Roche Ultra-Sensitive PCR

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Client Name: \_\_\_\_\_

Antiretroviral medications prescribed as of most recent outpatient visit: Check all that apply:

NRTI	NNRTI	PI	OTHER
<input type="checkbox"/> 3TC (lamivudine, Epivir®) <input type="checkbox"/> AZT (zidovudine, Retrovir®)  <input type="checkbox"/> ddI (didanosine, Videx®) <input type="checkbox"/> ddC (zalcitabine, Hivid®) <input type="checkbox"/> d4T (stavudine, Zerit®) <input type="checkbox"/> abacavir, Ziagen™ <input type="checkbox"/> Combivir® <input type="checkbox"/> Trizivir® <input type="checkbox"/> tenofovir (Viread®) <input type="checkbox"/> emtricitabine (Emtriva®) <input type="checkbox"/> tenofovir/ emtricitabine (Truvada®) <input type="checkbox"/> Epzicom®	<input type="checkbox"/> nevirapine (Viramune®)  <input type="checkbox"/> delavirdine (Rescriptor®)  <input type="checkbox"/> efavirenz (Sustiva®)	<input type="checkbox"/> indinavir sulfate (Crixivan®)  <input type="checkbox"/> ritonavir (Norvir®)  <input type="checkbox"/> saquinavir (Invirase®, Fortovase™) <input type="checkbox"/> nelfinavir (Viracept®) <input type="checkbox"/> amprenavir (Agenerase®) <input type="checkbox"/> lopinavir/ritonavir (Kaletra®) <input type="checkbox"/> Fosamprenavir (Lexiva®) <input type="checkbox"/> Atazanavir (Reyataz®) <input type="checkbox"/> darunavir (Prezista) <input type="checkbox"/> tipranavir (Aptivus)	<input type="checkbox"/> hydroxyurea, (Hydrea®)  <input type="checkbox"/> Enfuvirtide, (ENF, Fuzeon®) Separate application and approval process required <input type="checkbox"/> Atripla

**Patient's Mode of Transmission. Check all that apply:**

<input type="checkbox"/> MSM (Men who have sex with men) <input type="checkbox"/> IDU (Injection drug user) <input type="checkbox"/> MSM/IDU <input type="checkbox"/> Adult Hemophilic <input type="checkbox"/> Heterosexual with IDU <input type="checkbox"/> Heterosexual with MSM <input type="checkbox"/> Heterosexual with Hemophilic <input type="checkbox"/> Heterosexual with Transfusion <input type="checkbox"/> Heterosexual with HIV/AIDS <input type="checkbox"/> Transfusion <input type="checkbox"/> Risk not specified <input type="checkbox"/> Perinatal <input type="checkbox"/> Other: _____
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**If the patient is not currently on antiretroviral therapies (ART), he/she cannot be reimbursed by the NH CARE Program for any medication other than OI prophylaxis. Please check all that apply:**

<input type="checkbox"/> Client reports or has experienced adverse side effects to ART. <input type="checkbox"/> Client declined or refused ART. <input type="checkbox"/> Client was offered ART and is considering. <input type="checkbox"/> Client has had difficulty or may have difficulty complying with ART. <input type="checkbox"/> Not medically indicated. <input type="checkbox"/> Other: _____
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Is there a medical plan of care in place for this client?  Yes  No  
 Is the client currently employed, student, currently able to work or seeking employment?  Yes  No  
 Is the client currently asymptomatic?  Yes  No

**Diagnosis:**

HIV +, not AIDS       CDC-defined AIDS       First diagnosed with AIDS during past 12 months

Signature of Physician	Date
Physician's Name (Please Print):	License #

Mailing Address:

City/Town	State	Zip	Phone ( )
			Fax ( )

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# Home Care Clients Only

## Patient Medical Information to be completed by Physician

The information on this form is necessary to determine your patient's medical eligibility for the HomeNH CARE Program. All information on this form, or given over the phone, will be kept strictly confidential by the Department of Health and Human Services. Personal identifying information is never released. Please complete and return to:  
NH CARE PROGRAM, DEPARTMENT OF HEALTH AND HUMAN SERVICES,  
29 HAZEN DR, CONCORD NH 03301-6504 FAX: (603) 271-4934 Tel: (603) 271-4480

<b>Patient Last Name</b>	<b>Patient First Name</b>	<b>M.I.</b>	<b>D.O.B.</b>
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**Diagnosis/Active Problems at this Time:**

Primary: \_\_\_\_\_ Secondary: \_\_\_\_\_

**Aware of Diagnosis:**  Spouse/Partner  Parent(s)  Family members  Care Providers **Current Prognosis:**  Good  Fair  
 Guarded  Poor

Abbreviated History, Physical and Findings

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Patient's Clinical Status - (Federal definitions PL 101-166) (check (✓) best description)

**MEDICALLY DEPENDENT:** Requiring the routine use of appropriate medical services (which may include home intravenous drug therapy) to prevent or compensate for the individual's serious deterioration arising from infection with the etiologic agent for acquired immune deficiency syndrome of physical health or cognitive function; **AND** being able to avoid long-term or repeated care as an inpatient or resident in a hospital, nursing facility or other institution if home or community-based health services are provided to the individual.

**CHRONICALLY DEPENDENT:** Being unable to perform because of physical or cognitive impairment (without substantial assistance from another individual) arising from infection with the etiologic agent for acquired immune deficiency syndrome, at least 2 of the following activities of daily living: bathing, dressing, toileting, transferring and eating, or having a similar level of disability due to cognitive impairment.

V. Physician's Plan of Care/Home Care Services Required

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I **certify** that the care prescribed is medically necessary for proper care of this patient.

Physician's Signature: \_\_\_\_\_

Physician Name (Type or Print) : \_\_\_\_\_

Address: \_\_\_\_\_

# Don't make these common mistakes...

1. Did not attach verification or proof of income.
2. Did not have the physician complete Personal Medical Information on pages 7 and 8.
3. Did not sign the Client Certification, Authorization, and Release of Information Statements on pgs.4, 5 and 6.
4. Did not include ALL information on enrollment in Medicare, Medicaid, or private insurance plans.

These common errors ***SIGNIFICANTLY*** slow down your application.  
Please take the time to check your application now.

We're more than happy to help!  
If you need assistance, please call:  
1-800-852-3345 ext. 4480  
Monday - Friday 8:30 AM to 4:30 PM  
*TDD Access: 1-800-735-2964*

**Thank you** for completing all the requested information. Please send the application to the address below. You may cut and paste the address onto an envelope for speedy and accurate delivery or use the addressed stamped envelopes included with this application. Our office will let you or your case manager know if you qualify for the program within 10 working days of the receipt of the application.

PRISCILLA NEWTON  
NH CARE PROGRAM  
NH DEPT of HEALTH and HUMAN SERVICES  
29 HAZEN DR, CONCORD NH 03301-6504