UPDATED 6/2018

INSURANCE SERVICES PROGRAM
NEW CLIENT APPLICATION

Date of Application: ________________. My client ______________________________ is applying for the *Insurance Services Program.*

☐ I have confirmed that my client has a current Notice of Eligibility (NOE)

☐ I have attached the following documentation to process this application:

- ☐ Initiation of Services
- ☐ Copy of Client's Benefits & Pharmacy Service Summary
- ☐ Pro-Rata Assignment

My client has the following type of insurance policy:

☐ ACA Policy ☐ Employer-Sponsored Policy ☐ COBRA Policy ☐ Medicare/Medicaid Policy

Case Manager Attestations

☐ I have advised my client that co-payments WILL NOT BE MADE FOR:

- HIV Medications
- Erectile Dysfunction Medications
- Non-Formulary Medications (When/If Applicable)
- IV Medications
- Over-the-Counter Medications (Even If Scripted by a Physician)
- Nutritional Supplements Unless Approved by Exception on a Month-to-Month Basis

☐ I have advised my client that he/she may need to pay a share of costs based on income level (SEE CHART)

INITIAL CLIENT DEMOGRAPHICS *(please insert numerical codes as specified in County MAR memorandum)*					
Social Security Number		Gender	Ethnicity	Race	% Income	Housing/Living Arrangements
Medical Insurance	HIV/AIDS Status	Enrollment Status	DOB		Exposure

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

ESTIMATED ANNUAL SERVICE NEEDS			
HEALTH INSURANCE		PRESCRIPTION DRUG CO-PAYMENTS	
Premium Per Month ($300 Max)	$	Co-Payment Per Month ($120 Max)	$

SHARE OF COST (Example: Applying share of cost to $75 co-pay request) – NOT YET IMPLEMENTED

% FPL	% Share	$ Request	$ Due	$ Allowable	% FPF	% Share	$ Request	$ Due	$ Allowable
0%-199%	0%/Request	$75.00	$0.00	$75.00	251%-300%	10%/Request	$75.00	$7.50	$67.50
200%-250%	5%/Request	$75.00	$3.75	$71.25	301%-400%	Ineligible	NA	NA	NA

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 client's premium notice and/or 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:

Suncoast Health Council, Inc. Attn: Barbara Hay 9600 Koger Blvd - #221 St. Petersburg, FL 33702 FAX (727)570-3033