Florida Department of Health, HIV/AIDS Patient Care Programs

Patient Care Core Eligibility Statement of Agreement and Acknowledgement

Authorization to Release

Individuals wanting to enroll and receive HIV/AIDS Patient Care Program services are required to check the box on the form acceptance page that states “I attest that I have read and agreed to the terms and conditions stated in Statement of Agreement and Acknowledgement as indicated by submission of an online form” and click on the “I Accept” button. This allows the HIV/AIDS Patient Care Programs to release information to the entities listed on the form for the purposes of coordination of care, treatment and payment of services.

By checking the box on the form acceptance page that states “I attest that I have read and agreed to the terms and conditions stated in Statement of Agreement and Acknowledgement as indicated by submission of an online form” and clicking on the “I Accept” button you certify that you fully understand and agree to abide by the policies stated herein. All references to "program" or "programs" refers to the Florida Department of Health, HIV/AIDS Patient Care Programs to include Ryan White Part B, the AIDS Drug Assistance Program (ADAP), HOPWA and/or successor programs in which you participate or to which you apply for services.

Please read the following:

1. I certify that the information and documentation I submit for access to HIV/AIDS Patient Care Programs is true and accurate to the best of my knowledge. I understand that I may be disqualified from this program(s) and/or prosecuted for willfully providing false information.

2. I understand that the information requested is for the purpose of determining my eligibility for a state and federally funded program. The funding is limited and may expire at any time without extended or alternate funds being available and does not obligate the Department of Health to continue to supply HIV/AIDS Patient Care Program services (medications, insurance premiums, copays or deductibles or other related services) indefinitely. Service(s) through this program are supplied as a benefit and not as a right or entitlement.

3. If I am considered eligible for services, my information will be provided to contractual partners for the reasons explained in this document. Eligibility approval does not mean I will receive or be enrolled in all services. I understand each service may require additional information and that I must provide this information for verification before enrollment into said services.

4. Upon approval, my eligibility will expire after six months. I will be required to reapply and provide updated eligibility information to continue accessing services 30 days prior to the eligibility expiration date. I agree to submit periodic information regarding my continued eligibility for participation in the program(s), including proof of income, proof of residency, availability of health insurance coverage, and an updated and signed version of this form with my Recertification Application every 6 months per federal guidelines.

5. I agree to notify or to have my Medical Case Manager notify the program(s) of any circumstances affecting my participation in, or eligibility for, the program(s). I agree to notify the program(s) within ten (10) days of a change in address and understand that all program correspondence will be sent to the address I have on file with the program(s). I understand changes in my situation will be periodically evaluated to determine continued eligibility for the program(s).

6. I authorize the program to release my enrollment, eligibility and service records and other information necessary to facilitate the provision of program services to my physicians, other providers, treatment centers, pharmacy benefit managers, third party administrators, health insurers, pharmacies, insurance carriers and insurance benefits coordinators, or any entity under contract with the program.

7. If I request enrollment into Medical Case Management or request any service that requires coordination with a Medical Case Manager, my information will be shared with the Medical Case Management agency.

8. I understand that my records are protected under the Health Insurance Portability and Accountability Act, Pub. L 104-491, 110 Stat. 1936, enacted August 21, 1996, relating to confidentiality of medical information, and cannot be disclosed to any other entity except those referenced herein without my written consent. I do not have to consent to the release of this information. However, if I refuse to sign this authorization, I will be ineligible to receive services through this program.

9. I understand that I may revoke this authorization at any time in writing. However, the release shall remain valid for a period of 6 months from the date of acceptance, or until such time as I inform the Program in writing, of my wish to terminate services in the Program(s), except to the extent that action has been taken in reliance on this authorization.

10. I understand that my personal health information may be contained within any documents I choose to upload, including proof of an HIV positive test result. I understand Program staff may request and obtain my lab information from my provider or the state's Electronic Lab Reporting (ELR) system.

11. I agree to treat Programs staff with courtesy and consideration.

The agencies listed below and their subcontractors, are used to coordinate and verify eligibility for all services following the same confidentiality requirements identified above in statements 1-11:

- A.H. of Monroe County, Inc.
- Basic NWFL, Inc.
- Big Bend Cares, Inc.
- Centers for Medicare & Medicaid Services
- FL Department of Children and Family Services - (Medicaid verification)
- Heart of Florida United Way, Inc.
- OASIS, Inc.
- South Florida AIDS Network
- Well Florida Council, Inc.

If you are a Ryan White Part B client receiving services within the state's Emerging Metropolitan Area (EMA) or Transitional Grant Area (TGA), your records will be accessible by the Ryan White Part A designated agency.

Revocation of Authorization

Program participants enrolled in the HIV/AIDS Patient Care Programs have the right to revoke any previously signed Statement of Agreement and Acknowledgement form in writing at any time.