Ryan White Part B Instruction Manual for IDPH Website

Illinois Department of Public Health

This document explains the procedures for creating an Eligibility Assessment to receive services from Ryan White Part B Medication Assistance, and/or Premium Assistance and/or CARE Supportive Services.

525 West Jefferson

800-825-3518

217-785-8013

Rev: 04/09/2018

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

Ryan White Part B Eligibility Assessment Website Manual

Summary/Important Information______________________Page 3

Website Landing Page______________________________Page 4

Eligibility Assessment______________________________Pages 5-17

Using your Confirmation Number____________________Page 18

Required Documents_______________________________Pages 19-20

Web User Accounts________________________________Page 20

Summary/Important Information:

This guide is designed to assist individuals through the process of filling out a Ryan White Part B Eligibility Assessment.

IMPORTANT NOTE: All fields that are in bold are required fields and must be filled in before you will be allowed to submit an Eligibility Assessment for Ryan White Part B Program Services.

IMPORTANT NOTE: While completing the assessment DO NOT use the "Back Arrow" at the top of the browser page, and DO NOT use the enter key or backspace key to navigate fields as this will kick yourself out of the assessment process. To navigate the assessment please utilize either the "Tab" button or use your mouse to point and click to enter information into appropriate fields throughout the assessment. DO NOT use the two side buttons on your mouse if it has them, these button are defaulted to forward and backward for web surfing, clicking these will kick you out of the assessment process.

IMPORTANT NOTE: Supporting documentation being attached, faxed, emailed, or sent by mail cannot be older than 90 days of the submission of your Eligibility Assessment.

All copies of supporting documents must be Legible and Valid. If they are not, this will hold up the processing of your Eligibility Assessment.

At the bottom of the landing page there is critical information you need to know in order to properly use the website.

UPDATED 1/1/2016: Acceptable Proof of HIV Documentation:

- Preliminary positive rapid (e.g. ELISA) screening result **WITH** either a confirmatory 4th generation or Western Blot test result.
- Positive HIV RNA PCR test result.
- Detectable HIV Viral Load test result "HIV Quant, Copies/ML"
  - Undetectable or any value with a "<" (less than) indicator is not acceptable for use as proof of HIV.
- Physician affidavit that certifies the confirmation of HIV diagnosis. This can be on official letter head of provider (preferred), a printout from the provider's EMR system, or a copy of a medical record note/printout. If using a printout of a clinic's EMR system, the printout must contain the name of facility/system, medical provider name, and client name.
  - The documentation must clearly identify the person being verified; and must have the physician or their designee's signature and be dated.

In order to minimize any potential issues with this website, please use one of the following web browsers:

- Internet Explorer 7 or greater
- Firefox
- Chrome
- Safari on Mac or PC

If you are experiencing issues with the website, please refer to this section to ensure you have done everything you can to allow the website to operate appropriately.

Landing Page:

Illinois Ryan White Part B Program

Ryan White Part B Eligibility Assessment

Hotline 1-800-825-3518

The Illinois Ryan White Part B Program is authorized under the Ryan White CARE Act and is administered by the Illinois Department of Public Health (IDPH). The purpose of this program is to provide HIV positive individuals who reside in Illinois and who are low-income, uninsured or under insured with access to a wide variety of core and supportive services. Below are some of the services that are offered through this program to those who qualify.

Prescription Assistance

Prescription Assistance services are designed to provide assistance with and access to HIV/AIDS medications that are on the approved Ryan White Part B Formulary list.

Premium Assistance

This service is designed to assist individuals with payment of their health insurance premiums up to $750 per month for approved plans by the Ryan White Part B Program.

Care Services

These services include assistance with primary medical care, medical case management, mental health, dental care, transportation, housing, and other core and supportive services to assist the individual in maintaining good overall health.

Applying for Services

To receive any of the services available through Ryan White Part B Program, you must complete an Eligibility Assessment. This assessment will collect all information and supporting documentation needed to determine your eligibility for the program.

Please note that IDPH has taken into account the highly confidential information that you will be providing on this website and has taken steps to ensure this site is secure and meets all security requirements specified under HIPAA as well as the state AIDS Confidentiality Act.

For instructions on how to complete the Eligibility Assessment, click here.

To complete an Eligibility Assessment, please click here.

To check the status of a previously submitted Assessment, please click here.

The Illinois Ryan White Part B Program requires supporting documentation regarding your residency, household income, and a signed Authorization to Release. To download these documents, please click on the links below.

Authorization to Release

Privacy Practice

Verification of Residency

Household Income Statement

Affidavit of No Insurance Coverage

Tax Payment Authorization

ADAP Formulary and Prescribing Guidlines

Contract Pharmacy Incident Form

Prior Authorization for Hepatitis C

Prior Authorization for Atovaquone (Mepron)

Prior Authorization for Enfurvirtide (Fuzeon)

Prior Authorization for Valganciclovir hydrochloride (Valcyte)

Prior Authorization for Hormone Therapy

User Accounts

You can sign up for a user account to drastically decrease the time spent reapplying for services and to receive more options on receiving email or text message alerts when it is time to reapply.

For instructions on requesting a Web User Account, click here.

For a copy of the Web User Account Agreement, click here.

To log in with your issued Web User Account, click here.

In order to minimize any potential issues with this website, please use one of the following web browsers:

- Internet Explorer 7 or greater
- Firefox
- Chrome
- Safari on Mac or PC

THIS WEBSITE POWERED BY Provide ENTERPRISE

Eligibility Assessment:

Illinois Ryan White Part B Program

Ryan White Part B Eligibility Assessment

Hotline 1-800-825-3518

Authorization to Release Confidential Information

Please read all statements and sign in the space provided to certify that you have read and understand this authorization. All references to "Program" or "Programs" refers to the Illinois Department of Public Health, Ryan White Part B Program and/or successor programs in which you participate or to which you apply for services.

Purposes of Release:

1. I certify that the information in this application 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 on this application 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.
3. If I am considered eligible for services, my information will be utilized with our 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. Upon the conclusion of my six months, I will be required to reapply and provide updated eligibility information to continue accessing services. 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) as 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 thirty (30) 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 utilization 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, or entities that are under contract with the program with the understanding that my status will never be disclosed to entities not affiliated with the Ryan White Part B Program in the bullet point list below.
7. If I experience discrimination because of the release or disclosure of medical related information, I may contact the Illinois Department of Human Rights at (217) 785-5100 or (312) 814-6200. This agency is responsible for enforcing the Illinois Human Rights Act which provides certain protections for persons with disabilities.
8. 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 provider that the Care Connect Regional Lead Agent who is administering this program in my area assigns to me.
9. I acknowledge that my health insurance premiums (if applicable) are being paid by the program via a contractual third party payer source. In consideration of same, I hereby authorize and direct my health insurer to directly reimburse the IDPH for any unused premium payments should my insurance policy terminate or be cancelled for any reason, including but not limited to future ineligibility, death, voluntary termination, involuntary cancellation, or termination by operation of law.
10. I agree to indemnify and hold the Illinois Department of Public Health (IDPH) harmless from any and all claims for making premium reimbursement payments directly to the IDPH or any entity under contract with the IDPH in connection with Program Services. I agree to indemnify and hold the IDPH, or any entity under contract with the IDPH in connection with Program Services, harmless from any and all claims for receiving premium reimbursement payments directly from IDPH or my health insurer. This agreement shall be binding on my administrators, executors, heirs, successors and assigns and shall remain in full force and effect during the time period in which I am enrolled in the Program(s).
11. I agree to reimburse IDPH for any and all premium reimbursement payments that are paid to me in error during my enrollment.
12. 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, and Illinois Statute 410 ILCS 305 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.
13. I understand that I may revoke this authorization at any time in writing. However, the release shall remain valid for a period of 24 months from the date this form is signed, or until such time as I inform the administrator of the Program(s), in writing, of my wish to terminate services in the Program(s). I also understand that I will still be required to sign a new authorization form every 6 months to continue Ryan White Services. I also understand that each time I sign a new reauthorize on a 6 month basis for renewal purposes that any and all previous authorization(s) become null and void. This authorization refers to authorizing the release for a validity period spanning 24 month period from the date this form is signed for those instances when I may step away from care after a 6 month certification, which this authorization will provide permission for re-engagement activities to take place by designee(s) of the Department not to exceed the 24 months from the date of signature.

The agencies listed below are utilized to coordinate and verify eligibility for all services, and for treatment and care coordination with other program(s) within IDPH, following the same confidentiality requirements identified in he statements above:

- System Software Vendor*
- Premium Assistance Payment Vendor*
- Pharmacy Benefits Manager Vendor*
- Quality Assurance & Compliance Vendor*
- Centers for Medicare & Medicaid Services
- IL Department of Insurance
- DIS Outreach Specialists employed by IDPH and/or local Health Departments
- Chicago Department of Public Health
- IL Department of Employment Security - (Income Verification Services)
- IL Department of Health and Family Services - (Medicaid Verification Services)
- IL Department of Public Health programs per Illinois Statute 410 ILCS 305
- IL Department of Public Health's Office of Health Protection Sections and Programs
- All Ryan White funded Providers

* Specific vendor information can be requested at: https://www.wh1.ioc.state.il.us

Accept   Do Not Accept

- You will need to click the "Accept" button to continue filling out an Eligibility Assessment for Ryan White Part B Program Services.

Main Tab:

Main | Demographics | Address | Household | Income | Benefits | Insurance | Medical | Care Team | Services

Alert

All fields that are bold are required and must be filled in before you will be allowed to submit the assessment. While completing the assessment DO NOT use the Back Arrow at the top of the browser page, and do not use the enter key to navigate fields as this will lock you out of the assessment. To navigate the assessment please utilize either the Tab button or use your mouse to point and click to enter information into appropriate fields throughout the assessment.

If you are applying more than 60 days prior to your eligibility expiration date, your eligibility will not be extended.

Applicant Identification

Legal First Name:
Legal Middle Initial:
Legal Last Name:
Name Suffix:
Preferred Name:
Date of Birth:
Social Security #:
Current Gender:
Gender at Birth:

Assessment Assistance

This section allows you to acknowledge any assistance you received in submitting your assessment. If you did not receive assistance in submitting this assessment, please select "Self" from the list below. Otherwise, choose the type of provider you received assistance from, select the agency from the drop down list and enter the first and last name of the individual who provided you assistance.

Assessment Assistance:

Authorization To Release

Attach a copy of a signed Authorization to Release.

Click to select files to attach ==>: Choose Files No file chosen

Privacy Practice

Attach a copy of a signed Privacy Practice.

Click to select files to attach ==>: Choose Files No file chosen

All fields that are **Bold**, must be filled out. You will not be able to submit your eligibility assessment without filling in these fields.

All clients must submit signed and dated Authorization to Release, and Privacy Practice forms along with each eligibility assessment.

You will have to option to attach documentation on each page of the eligibility assessment.

Authorization To Release

Attach a copy of a signed Authorization to Release.

Click to select files to attach ==>: Choose Files No file chosen

Privacy Practice

Attach a copy of a signed Privacy Practice.

Click to select files to attach ==>: Choose Files No file chosen

If you do not have the ability to scan and attach documents to your online eligibility assessment, you may fax, or mail documentation to the Illinois Department of Public Health Ryan White Part B program.

Fax to: 217-785-8013

Mail to: Illinois Department of Public Health
Attn: Ryan White Part B
525 West Jefferson Street
Springfield, IL 62761

Demographics Tab:

Demographics

Race - Check all that apply:
- ☐ Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native American
- ☐ Native Hawaiian
- ☐ Pacific Islander
- ☐ White

Ethnicity: [▼]
Veteran? [▼]
Marital Status: [▼]

Demographics: All fields are required to be filled out.

If you select Hispanic for Ethnicity, another dropdown will appear:

Demographics

Race - Check all that apply:
- ☐ Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native American
- ☐ Native Hawaiian
- ☐ Pacific Islander
- ☐ White

Ethnicity: [Hispanic ▼]

Hispanic - Check all that apply:
- ☐ Mexican
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Other

Veteran? [▼]
Marital Status: [▼]

If you select Legal Separation for Marital Status, you will be prompted to attach legal Separation documentation:

Demographics

Race - Check all that apply:
- ☐ Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native American
- ☐ Native Hawaiian
- ☐ Pacific Islander
- ☐ White

Ethnicity: [Hispanic ▼]

Hispanic - Check all that apply:
- ☐ Mexican
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Other

Veteran? [▼]
Marital Status: [Legal Separation ▼]

Legal Separation

Attach a copy of Legal Separation documentation.

Click to select files to attach ==>: [Choose Files] No file chosen

Address Tab:

Main | Demographics | Address | Household | Income | Benefits | Insurance | Medical | Care Team | Services

Alert

If you are applying more than 60 days prior to your eligibility expiration date, your eligibility will not be extended.

PO Box numbers are not accepted as proof of residency.

Street Address cannot contain abbreviations. All street names need to be fully spelled out.

Residence

Housing Status:
Street Address:
Apt / Lot / Floor:
City:
County:
State:
Zip Code:
Primary Phone:
Secondary Phone:

Mailing Address

Do you consent to receiving mail from the program?

Proof of Residency

Click to select files to attach ==>: Choose Files No file chosen

All Bold items must be filled out.

Entering your phone number is recommended, but not required. This will allow staff members to contact you in the event that important documentation is needed to complete your application.

Consent to receive mail is recommended, but not required. This will allow the program to mail you important reapplication information.

Household Tab:

Household

# of Additional Household Members: 0

If you live alone, and do not have any legal dependents, leave this as zero, and move to the next tab of the eligibility assessment.

Our program recognizes the following individuals as legal dependents:

Children 17 years or younger
Adult children 18 – 26 years old that are currently attending an institution of higher learning
Children of any age that receive Social Security Disability benefits, and resides with the client
Spouse and Civil Union Partners
Legal Guardians
Legal Caregivers

If any of these apply, you may include them in the household. Do so by changing the number from 0 to the accurate number of legal dependents, and press the enter key on the keyboard. Once the number of household members is changed, a new box will appear.

Household

# of Additional Household Members: 1

Contact 1

First Name:
Last Name:
Okay to Speak with?
Date of Birth:
Relationship to Client:
Is this person your emergency contact?
Gender:
Race - Check all that apply:
- Alaskan Native
- Asian
- Black or African American
- Native American
- Native Hawaiian
- Pacific Islander
- White

Ethnicity:
Disabling Condition?
Do you claim this individual or does this individual claim you as a dependent or spouse on a tax return?

All fields must be completed.

Income Tab:

Current Monthly Household Income

Wages, salaries, tips, etc. (Form W-2):

Taxable interest (1099-INT form):

Tax-exempt Interest (Form 1099-INT box 8):

Ordinary Dividends (1099-DIV box 1a):

Exempt Interest Dividends (Form 1099-INT box 10):

Taxable refunds of state/local income taxes:

Alimony or Other Spousal Support Received:

Business or Self Employed income/loss (Schedule C or C-EZ):

Capital gain/loss (Schedule D):

Other gains/losses (Form 4797):

IRA distributions – taxable amount:

Pensions and Annuities:

Rental real estate, trusts (Schedule E):

Farm income/loss (Schedule F):

Unemployment Income:

Retirement Income from Social Security:

Social Security Disability (SSDI):

SUPPLEMENTAL SOCIAL SECURITY INCOME (SSI):

Other Client Income (Jury Duty Pay, Gambling Winnings):

CHILD SUPPORT, WORKMAN'S COMPENSATION, OR MONETARY GIFT:

Current Monthly Household Income Adjustments

Educator expenses:

Business expenses (Form 2106 or 2106-EZ):

Health Saving Account (Form 8889):

Moving Expenses (Form 3903):

Deductible part of Self-Employment Tax (Schedule SE):

Self-employed SEP, SIMPLE plans:

Self-employed Health Insurance Deduction:

Penalty on early withdrawal of savings:

Alimony paid:

IRA deduction:

Student loan interest deduction:

Tuition and fees (Form 8917):

DOMESTIC PRODUCTION ACTIVITIES (Form 8903):

Totals

Household Monthly Gross Income: $0.00

Household Monthly Gross Income Adjustments: $0.00

Household Monthly MAGI: $0.00

Tax Return

Did you file a tax return for the most recent prior year?

Income Documentation

Click to select files to attach ==>: Choose Files No file chosen

All fields must be completed. If you do not have income for a specific section, you must place a zero on this line.

Benefits Tab:

Do you have Active Medicare?

Medicare

Status: [▾]

If not, select No Benefits.
If yes, you should set this to Active, and more information will be required.

Medicare

Status: Active ▾
Medicare Coverage: [▾]
Medicare ID: [ ]

Attach a copy of the front and back of your red, white and blue card.

Click to select files to attach ==>: Choose Files No file chosen

Medicare Part D

Status: [▾]

Medicare Supplemental

Status: [▾]

You must now select the type of Medicare Coverage that you currently have. If you have A and B only, you will enter the required information in the first section labeled Medicare. If you are currently enrolled in a Medicare Part D, and/or a supplemental plan, you should enter this information in the appropriate fields. Once you select Active for Medicare Part D or Supplemental, you will be required to enter the appropriate information for each plan.

Medicare Part D

Status: Active ▾
Insurance Company Name: [ ]
Insurance Plan Name: [ ]
Group ID: [ ]
Member ID: [ ]
Bin #: [ ]
Benefits Phone: [ ]

Attach a copy of the front and back of your Medicare D card.

Click to select files to attach ==>: Choose Files No file chosen

Medicare Supplemental

Status: Active ▾
Insurance Company Name: [ ]
Plan Name: [ ]
Plan Type: [▾]
Group Number: [ ]
Member ID: [ ]
Bin #: [ ]
Benefits Phone: [ ]

Attach a copy of the front and back of your Medicare Supplemental card.

Click to select files to attach ==>: Choose Files No file chosen

Insurance Tab:

Primary Private Insurance

Status:

Prescription Only Benefit Plan

Status:

Dental Care Policy

Status:

Vision Care Policy

Status:

Do you have Active Medical, Dental, or Vision insurance? Select Active for each that you have, and No Benefits for each that you do not have. If you select Active, you will be required to provide more information.

Primary Private Insurance

Status: Active
Source:
Insurance Company Name:
Insurance Plan Name:
Group Number:
Member ID:
Benefits Phone:
Pharmacy Coverage Included?

Attach a copy of the front and back of your Primary Private Insurance card and prescription benefit card if separate.

Click to select files to attach ==>: Choose Files No file chosen

Prescription Only Benefit Plan

Status: No Benefits

Secondary Private Insurance

Status: No Benefits

Dental Care Policy

Status: Active
Insurance Company Name:
Plan Name:
Group Number:
Member ID:
Benefits Phone:

Attach a copy of the front and back of your Dental Insurance card.

Click to select files to attach ==>: Choose Files No file chosen

Vision Care Policy

Status: No Benefits

All fields must be completed.

Medical Tab:

HIV Status

Stage of Disease: [ ]

Date HIV Diagnosed: [ ]

Identified Risk Factor(s):
- Blood Transfusion
- Hemophilia
- Heterosexual Contact
- Intravenous Drug Use
- Men Who Have Sex with Men
- Mother-at-Risk (Perinatal)
- Other
- Undetermined

Lab Results

Will you be attaching your most recent CD4 Count Lab Results? [ ]

Will you be attaching your most recent HIV 1 Viral Load Results? [ ]

Proof of HIV

Acceptable Proof of HIV Documentation:

Click to select Proof of HIV files to attach ==>: Choose Files No file chosen

All Fields must be completed

If you select CDC – defined AIDS, you will need to enter the date of AIDS diagnosis.

CD4 lab results are recommended but not required.

HIV viral load lab results must be submitted during each enrollment period. HIV viral load test results must have a date of collection within 6 months of each eligibility assessment submission. If you answer yes to "Will you be attaching your most recent HIV Viral Load Results?" you will be required to supply more information.

Lab Results

Will you be attaching your most recent CD4 Count Lab Results? No

Will you be attaching your most recent HIV 1 Viral Load Results? Yes

Date of Most Recent Viral Load: [ ]

Viral Load Result Modifier: [ ]

Viral Load Result: [ ]

Click to select Viral Load Lab Results files to attach ==>: Choose Files No file chosen

Proof of HIV

Acceptable Proof of HIV Documentation:

Click to select Proof of HIV files to attach ==>: Choose Files No file chosen

Our program requires that all enrollees submit proof of HIV diagnosis. Unlike lab documentation, this document only needs to be submitted one time, and will carry over during each enrollment. The following are acceptable as proof of diagnosis:

- Preliminary Positive screening result WITH either a confirmatory 4th generation or Western Blot test result
- Detectable HIV RNA PCR test result (HIV Viral Load Result)
- Physician affidavit that certifies the confirmation of HIV diagnosis

Care Team Tab:

HIV Care Physician

...First Name:
...MI:
...Last Name:
Facility Name:
Street Address:
City:
State:
Zip:
Phone:

HIV Prescribing Physician

Does your HIV Care Physician also prescribe your HIV medications?

HIV Care Physician information is not required for the submission of your eligibility assessment, but will be necessary to remain enrolled in the program. If you choose not to enter your physician information on this eligibility assessment, you will be required to submit this information to the Program within 90 days. Failure to do so will result in your termination from the Program.

If your HIV Prescribing Physician is different than your HIV Care Physician, you will need to supply this additional information:

HIV Prescribing Physician

Does your HIV Care Physician also prescribe your HIV medications? No

...First Name:
...MI:
...Last Name:
Facility Name:
Street Address:
City:
State:
Zip:
Phone:

Services Tab:

CARE Services Definition

Care Services include primary medical care, dental care, mental health counseling. NOT ALL SERVICES MAY BE AVAILABLE IN YOUR AREA.

CARE Services

Do you want to add/continue CARE Services? [ ]

Medication Assistance

Do you want to add/continue Medication Assistance? [ ]

All fields must be completed.

If you select "Yes" for either option, you will need to provide more information.

CARE Services

Do you want to add/continue CARE Services? Yes

Care Service(s) Desired:

- Early Intervention Services
- Emergency Financial Assistance
- Food Bank Home / Delivered Meals
- Housing Services
- Legal Services
- Linguistic Services
- Medical Case Management
- Medical Nutrition Therapy
- Medical Transportation Services
- Mental Health Services
- Oral Health Care
- Outpatient Ambulatory Care
- Outreach Services
- Permanency Planning
- Psychosocial Support
- Rehabilitation Services
- Substance Abuse Services (Outpatient)
- Treatment Adherence (non-clinical)

Medication Assistance

Do you want to add/continue Medication Assistance? Yes

Medication Mailing Address

Medication mailing address cannot be a PO Box.

If you are homeless or do not have a stable residence please select No and provide the address to a facility that will accept your med

If you are requesting drugs to be shipped to a facility for pickup, failure to pickup or claim two shipments will result in you being plac

Same as Residency Address? [ ]

If you do not wish to receive Medication shipped to your residence you should mark "Same as Residency" to "No." You will need to supply the address to which you wish to have your medications shipped.

If you entered Medicare Part D, Medicare Supplemental, Private Medical, Dental, and/or Vision insurance information, you will have the option to sign up for our Premium Assistance Program.

The Premium Assistance program assists individuals in paying monthly insurance premiums for qualified plans.

CARE Services Definition

Care Services include primary medical care, dental care, mental health counseling. NOT ALL SERVICES MAY BE AVAILABLE IN YOUR AREA.

CARE Services

Do you want to add/continue CARE Services?

Medication Assistance

Do you want to add/continue Medication Assistance?

Primary Private Insurance

Premium Assistance Requested?

Dental Care Policy

Premium Assistance Requested?

If you wish to be enrolled in the Premium Assistance Program, you will need to select "Yes" for each plan that you wish to receive assistance, and fill out all required fields.

Medication Assistance

Do you want to add/continue Medication Assistance? Yes

Medication Mailing Address

Medication mailing address cannot be a PO Box.

If you are homeless or do not have a stable residence please select No and provide the address to a facility that will accept your

If you are requesting drugs to be shipped to a facility for pickup, failure to pickup or claim two shipments will result in you being

Same as Residency Address? Yes

Primary Private Insurance

Premium Assistance Requested? Yes

Are your Premiums Auto Deducted?

Premium Payment Amount:

Premium Payment Frequency:

Are you overdue on Premium payment?

Premium Payee Name:

Street Address 1:

Street Address 2:

City:

State:

Zip:

Attach a copy of your premium coupon/invoice dated within the last 90 days. Coupon or invoice must contain the premium mailin

Click to select files to attach ==>: Choose Files No file chosen

Dental Care Policy

Premium Assistance Requested? No

All bold fields must be completed

Submitting an Assessment:

Illinois Ryan White Part B Program

Ryan White Part B Eligibility Assessment

Hotline 1-800-825-3518

Submit Assessment

Main | Demographics | Address | Household | Income | Benefits | Insurance | Medical | Care Team | Services

Click the Blue “Submit Assessment” link in the upper right hand corner.

Errors – if found:

Main | Demographics | Address | Household | Income | Benefits | Insurance | Medical | Care Team | Services

Alert

If you are applying more than 60 days prior to your eligibility expiration date, your eligibility will not be extended.

CARE Services Definition

Care Services include primary medical care, dental care, mental health counseling. NOT ALL SERVICES MAY BE AVAILABLE IN YOUR AREA.

CARE Services

Do you want to add/continue CARE Services? No

Medication Assistance

Do you want to add/continue Medication Assistance? Yes

Medication Mailing Address

Medication mailing address cannot be a PO Box.

If you are homeless or do not have a stable residence please select No and provide the address to a facility that will accept your medication shipment. Preferably a local CVS Retail Pharmacy.

If you are requesting drugs to be shipped to a facility for pickup, failure to pickup or claim two shipments will result in you being placed on a Medication HOLD and will no longer be allowed to have drugs shipped to a facility.

Same as Residency Address? Yes

Please fix the following errors:

Insurance

- Status: This field is required.

Medical

- Date HIV Diagnosed: This field is required.

Care Team

- Does your HIV Care Physician also prescribe your HIV medications?: This field is required.

- After clicking the “Submit Assessment” button, if any errors are found on the assessment they will be stated in the red box as shown above. It will state where the error is on the assessment.
- All errors must be corrected before the assessment may be submitted
- Once all errors have been corrected, you will need to click “Submit Assessment” again.
- After a successful submission, the Confirmation Page will be displayed.
- Keep your Confirmation number for you records

Illinois Ryan White Part B Program

Hotline 1-800-825-3518

Application Submission Successful

Your application has been successfully submitted. Your confirmation code is: **1039070**

This is your Confirmation Number – Keep it

Please print and keep a copy of this page for future reference.

Your assessment has been submitted but it appears to be missing the following documentation:

- A completed and signed Authorization to Release document
- Proof of Residency
- Proof of Income
- Proof of Medicare Insurance
- Proof of Medicare Part D Insurance
- Proof of Medicare Supplemental Insurance
- Proof of Primary Private Insurance

You have 15 business days to submit all the missing documentation listed above. You can submit this information via fax to 217-785-8013 or by mail to the following address:

Illinois Department of Public Health – Ryan White Programs
525 West Jefferson Street
Springfield, IL 62761

Attention: It may take up to 7 business days for your assessment to be updated once you have faxed documents to the Ryan White Office.

Please wait 7 business days prior to calling the Ryan White Office inquiring about the status of your faxes.

Return to Eligibility Assessment Home Page

Click to Print This Page

You may check on the status of your eligibility assessment at any time. You may do so by clicking on the "To check the status of a previously submitted Assessment, please click here" link.

Illinois Ryan White Part B Program

Ryan White Part B Eligibility Assessment

Hotline 1-800-825-3518

The Illinois Ryan White Part B Program is authorized under the Ryan White CARE Act and is administered by the Illinois Department of Public Health (IDPH). The purpose of this program is to provide HIV positive individuals who reside in Illinois and who are low-income, uninsured or under insured with access to a wide variety of core and supportive services. Below are some of the services that are offered through this program to those who qualify.

Prescription Assistance

Prescription Assistance services are designed to provide assistance with and access to HIV/AIDS medications that are on the approved Ryan White Part B Formulary list.

Premium Assistance

This service is designed to assist individuals with payment of their health insurance premiums up to $750 per month for approved plans by the Ryan White Part B Program.

Care Services

These services include assistance with primary medical care, medical case management, mental health, dental care, transportation, housing, and other core and supportive services to assist the individual in maintaining good overall health.

Applying for Services

To receive any of the services available through Ryan White Part B Program, you must complete an Eligibility Assessment. This assessment will collect all information and supporting documentation needed to determine your eligibility for the program.

Please note that IDPH has taken into account the highly confidential information that you will be providing on this website and has taken steps to ensure this site is secure and meets all security requirements specified under HIPAA as well as the state AIDS Confidentiality Act.

For instructions on how to complete the Eligibility Assessment, click here.

To complete an Eligibility Assessment, please click here.

To check the status of a previously submitted Assessment, please click here.

You will be directed to the following page, where you will need to enter your Confirmation Number.

Illinois Ryan White Part B Program

Ryan White Part B Eligibility Assessment

Hotline 1-800-825-3518

Lookup a Submitted Assessment

Please enter your confirmation code below and click "Submit" to retrieve the status of your Eligibility Assessment.

Retrieve Assessment Status

Confirmation Code:

Submit

Once you click submit, you will be given information regarding the status of your application.

Assessment ID

The current status of your Eligibility Assessment is Submitted and is being processed but has been flagged as incomplete.

In addition, the following required documentation has been flagged as insufficient:

Proof of Income
Missing 1 more pay stub dated in the last 90 days, currently year to date gross is showing over income requirements for our program.

Proof of Dental Coverage
Missing Employer based Dental and vision insurance cards

Proof of Vision Coverage

Recent Primary Private Insurance Premium Statement
We cannot pay for Employer based coverage

Please contact the Ryan White Program office at 800-825-3518 or 217-524-5983 if you have further questions.

Return to Eligibility Assessment Home Page

Required Documentation:

The next section provides you with links to the various forms that may be needed/required in order to submit a complete assessment.

The Illinois Ryan White Part B Program requires supporting documentation regarding your residency, household income, and a signed Authorization to Release. To download these documents, please click on the links below.

Authorization to Release

Privacy Practice

Verification of Residency

Household Income Statement

Affidavit of No Insurance Coverage

Tax Payment Authorization

ADAP Formulary and Prescribing Guidlines

Contract Pharmacy Incident Form

Clicking on these links will open the document in PDF format and allow you to fill out the form electronically where applicable. You must then print the document, sign and date it. It is important to remember that this document must be provided to the Program.

You can upload the document into the assessment directly as described in the previous section or you can submit this document to the Program via email at DPH.ADAPFax@illinois.gov (unsecure) or by faxing them to 217-785-8013 (secure.)

The Program requires various forms and supporting documentation with every assessment which are detailed below.

All copies of supporting documents **must** be legible and meet the requirements outlined below. Failure to provide documents that meet these requirements will result in delays to the processing of your assessment.

Authorization to Release

Every assessment must include an updated Authorization to Release form that is signed and dated within 90 days from the date of the submission of the assessment.

Privacy Practice

Every assessment must include an updated Privacy Practice form that is signed and dated within 90 days from the date of the submission of the assessment.

Proof of Residency

Every assessment must include documentation supporting the residency information entered on the Address tab. This documentation must be dated within 90 days from the date of the submission of the assessment unless providing a rental or mortgage agreement which must be dated within the last 12 months. A valid (not expired) State issued ID is also acceptable.

Proof of Income

Every assessment must include documentation supporting the income information entered on the Income tab including a completed, signed and dated Household Income Statement dated within 90 days from the date of the submission of the assessment. If providing documents regarding Social Security income, pension or unemployment award letters, or federal tax returns, these documents must be dated within the last 12 months.

Documentation of any Insurance Coverage

Every assessment must include documentation supporting the insurance information entered on the Benefits and Insurance tabs. This documentation must include copies of the front and back of all insurance cards. If you do not have insurance coverage, you will need to submit a signed and dated Affidavit of No Insurance Coverage. If you are requesting premium assistance, you will need to submit an insurance billing statement that is dated within the last 90 days.

Viral Load Test Results

Every assessment must include documentation of Viral Load test results received within six months from the date of the submission of the assessment. Failure to provide these results will result in a 90 day conditional approval only if all other requirements are met, and will only be provided once. If provided, you must obtain these lab results within the 90 days in order to avoid termination of services.

Web User Accounts:

The landing page also has a section for requesting and logging into your Web User Account.

User Accounts

You can sign up for a user account to drastically decrease the time spent reapplying for services and to receive more options on receiving email or text message alerts when it is time to reapply.

For instructions on requesting a Web User Account, click here.

For a copy of the Web User Account Agreement, click here.

To log in with your issued Web User Account, click here.

The Program ***strongly*** encourages you to set up an account because of the benefits that it provides. This account allows you to create an Eligibility Assessment that is prepopulated with your current information that is on file with the Program. This reduces the amount of work you need to do to fill in the assessment. All you need to do is correct any wrong or outdated information and upload new documents as needed.

This account also allows you to elect to receive email and/or text message alerts regarding status updates to your future assessments as well as your upcoming eligibility recertification deadlines.

To request a Web User Account be setup for you, you must visit one of the Department's authorized partners. For further instruction click the link on the landing page that is shown above "For instructions on requesting a Web User Account, click here"