ADPH ADAP FORM:
EMPLOYER-SPONSORED INSURANCE ATTESTATION

This form is an extension of the ADPH ADAP Service Point application. All information provided is expected to be accurate and true.

In accordance with HRSA HAB PCN 13-04 and 21-02, all RWHAP funds used to support the Alabama ADAP are used as payer of last resort. RWHAP funds are not used "for any item or service to the extent that payment has been made, or can reasonably be expected to be made…" by another payment source. To ensure compliance with the payer of last resort requirement, ADAP staff and agencies funded by ADPH must:

1. Vigorously pursue client enrollment into health care coverage for which clients may be eligible (e.g., Medicaid, CHIP, Medicare, state-funded HIV/AIDS programs, employer-sponsored insurance, and/or private health insurance).
2. Ensure that clients are enrolled in health care coverage whenever possible or applicable, and are informed about the consequences of not enrolling.

To meet these requirements, ADPH RWHAP Part B sub-recipients (case management agencies) must **maintain policies and document their efforts** to ensure that they assist clients to vigorously pursue enrollment in health care coverage and that clients have accessed all other available public and private funding sources for which they may be eligible prior to and while enrolled in ADPH ADAP (HRSA HAB PCN 21-02).

To be eligible for the Alabama ADAP, individuals must be ineligible[1] for third-party payors, including but not limited to employer-sponsored insurance, COBRA, and Alabama Medicaid. Individuals must document this with any of the following information:

1. Copy of letter detailing ineligible for/unavailable employer sponsored insurance
2. Copy of letter detailing waiting period for employer sponsored insurance
3. Copy of denial letter for COBRA access.
4. Copy of denial letter from Alabama Medicaid

ADPH RWHAP Part B sub-recipients can continue providing services funded through RWHAP to a client who remains unenrolled in other health care coverage **so long as there is rigorous documentation that such coverage was vigorously pursued** (HRSA HAB PCN 21-02). This form is required to be used to document the efforts of case managers/social workers to attain coverage for individuals seeking enrollment in ADPH ADAP.

Case manager instructions:

1. If the client is unable to document employer-sponsored insurance, case manager must complete the following attestation form to document eligibility for employer-sponsored insurance.
2. Once complete, attach to the client profile in Service Point.
3. If an individual has been offered and enrolled in employer-sponsored insurance, please attach a copy of the individual's insurance card and insurance booklet containing their full prescription coverage and benefit.

[1] Ineligible is defined as the individual being denied access to or ineligible for third-party insurance (i.e., employer-sponsored insurance). An individual cannot "opt-out" of third-party insurance for which they are eligible and be determined eligible for ADAP.

INDIVIDUALS INFORMATION *(required)*	
Legal First Name	
Legal Last Name	
Date of birth (MM/DD/YYYY)	
ServicePoint ID	

SCREENING		
I hereby certify that the information provided on this form is accurate to the best of my knowledge.		
The individual is employed.	☐ **Yes** ☐ **No** If **yes**, proceed to next question. If **no**, stop screening.	
Enter employer name (i.e., company/individual name)		
The individual was offered employer-sponsored insurance.	☐ **Yes** ☐ **No** If **yes**, proceed to next question. If **no**, stop screening. If the individual **does not know**, the individual should be instructed to follow-up with their employer to learn if insurance is offered by their company.	
The individual accepted the employer-sponsored insurance.	☐ **Yes** ☐ **No** If **yes**, proceed to next question. If **no**, the individual should be informed about payer of last resort requirements for the Alabama ADAP as documented at the top of page 1 of this form. The individual should be instructed to follow-up with their employer to learn if they can still participate in their employer's insurance. If the individual **refuses to participate in employer-sponsored insurance**, the individual will be denied coverage by the Alabama ADAP for failure to enroll in employer-sponsored insurance. If the individual **will participate in employer-sponsored insurance but must wait until next enrollment cycle**, the individual will be enrolled in ADAP-Rx only while awaiting employer-sponsored insurance coverage. The individual will be disenrolled from Alabama ADAP upon enrollment in employer-sponsored coverage.	
CHOOSE ONE OPTION	Client is enrolled in employer-sponsored insurance and plan has taken effect. Date on which the insurance plan began (past date)	
	Client has applied for employer-sponsored insurance plan but plan has not taken effect. Date on which the insurance will begin (future date)	
	Client does not know the date their insurance policy will take effect, but employer open enrollment period is defined as (future date)	

DOCUMENTATION OF REQUEST FOR INFORMATION

Please include below all requests made to individuals' employer to document employer-sponsored insurance, including, but not limited to, date of start of coverage, type of insurance, individual eligibility for employer-sponsored insurance, etc.

For each outreach effort conducted, please include a separate entry into the log below.

Is outreach to the individual or on behalf of the individual to their employer necessary?		☐ **Yes** ☐ **No** If **yes**, complete the log below. If **no**, skip to attestation.
First outreach to individual or employer	Date of outreach:	
	Reason for outreach:	
	Outcome of outreach:	
	How outreach was conducted:	☐ **Phone** ☐ **E-mail** ☐ **Other: please describe**
	Is follow-up necessary:	☐ **Yes** ☐ **No**
Second outreach to individual or employer	Date of outreach:	☐
	Reason for outreach:	☐
	Outcome of outreach:	☐
	How outreach was conducted:	☐ **Phone** ☐ **E-mail** ☐ **Other: please describe**
	Is follow-up necessary:	☐ **Yes** ☐ **No**
Third outreach to individual or employer	Date of outreach:	☐
	Reason for outreach:	☐
	Outcome of outreach:	☐
	How outreach was conducted:	☐ **Phone** ☐ **E-mail** ☐ **Other: please describe**
	Is follow-up necessary:	☐ **Yes** ☐ **No**

Fourth outreach to individual or employer	Date of outreach:	☐
	Reason for outreach:	☐
	Outcome of outreach:	☐
	How outreach was conducted:	☐ **Phone** ☐ **E-mail** ☐ **Other: please describe**
	Is follow-up necessary:	☐ **Yes** ☐ **No**
Fifth outreach to individual or employer	Date of outreach:	☐
	Reason for outreach:	☐
	Outcome of outreach:	☐
	How outreach was conducted:	☐ **Phone** ☐ **E-mail** ☐ **Other: please describe**
	Is follow-up necessary:	☐ **Yes** ☐ **No**

ATTESTATION *(required)*	
I hereby certify that the information provided on this form is accurate to the best of my knowledge. I also certify that I reviewed this information with the client and the information provided to determine ADAP eligibility is complete and correct. I have advised the client that intentionally withholding and/or providing false or misleading information will result in immediate denial or termination of all Ryan White Part B funded services, including ADAP services.	
Case Manager/Social Worker printed name	
Case Manager/Social Worker signature	
Date form is being completed (MM/DD/YYYY)	