

Form J - Ryan White Part B Program

Application Instructions



The Ryan White Part B Program gives help to low income people living with HIV/AIDS in Maine.

<p>Use this application to be reimbursed for a medication copayment.</p>	<p>Copay reimbursements are available for people with HIV/AIDS who:</p> <ul style="list-style-type: none"> • live in Maine; • make less than 500% of the federal poverty level (https://aspe.hhs.gov/poverty-guidelines); • are required to use a pharmacy that will not contract with ADAP; AND • the medication is on the ADAP formulary (www.maine.gov/dhhs/MaineADAP).
<p>What you need to apply:</p>	<ul style="list-style-type: none"> • Complete and sign the 1-page application • Attach itemized receipts for medications filled within 90 days
<p>How you apply:</p>	<ul style="list-style-type: none"> • Send your completed application and receipts to: Maine Ryan White Program 40 State House Station Augusta, ME 04330 Fax: (207) 287-3498
<p>What happens next?</p>	<ul style="list-style-type: none"> • Fill out the application completely and clearly. We cannot process applications with missing information. (Your Ryan White ID is the same DHS number you use for ADAP.) • Once we receive your complete application, you will get a letter confirming payment or explaining why your request was denied. • Please allow up to ten business days for your application to be processed. If you do not hear from us in ten business days, please call us.
<p>Get help with this application</p>	<ul style="list-style-type: none"> • Phone: (207) 287-3747. TTY users call Maine Relay 711 • Fax: (207) 287-3498 • Email: RyanWhitePartB.DHHS@maine.gov

In accordance with 22 MRS §15, any person who knowingly makes any false written statements or knowingly submits any false documents to receive benefits provided by the Department may face civil penalties by the State of Maine in the Superior Court, which may include, but is not limited to, recovery of those funds disbursed.

Maine Department of Health and Human Services NONDISCRIMINATION NOTICE

The Department of Health and Human Services (“DHHS”) does not discriminate on the basis of disability, race, color, sex, gender, sexual orientation, age, national origin, religious or political belief, ancestry, familial or marital status, genetic information, association, previous assertion of a claim or right, or whistleblower activity, in admission or access to, or the operation of its policies, programs, services, or activities, or in hiring or employment practices. This notice is provided as required by and in accordance with Title II of the Americans with Disabilities Act of 1990 (“ADA”); Title VI of the Civil Rights Act of 1964, as amended; Section 504 of the Rehabilitation Act of 1973, as amended; Age Discrimination Act of 1975; Title IX of the Education Amendments of 1972; Section 1557 of the Affordable Care Act; the Maine Human Rights Act; Executive Order Regarding State of Maine Contracts for Services; and all other laws and regulations prohibiting such discrimination. Questions, concerns, complaints or requests for additional information regarding the ADA and *hiring or employment practices* may be forwarded to the DHHS ADA/EEO Coordinators at 11 State House Station, Augusta, Maine 04333-0011; 207-287-4289 (V); 207-287-1871(V); or Maine Relay 711 (TTY). Questions, concerns, complaints or requests for additional information regarding the ADA and *programs, services, or activities* may be forwarded to the DHHS ADA/Civil Rights Coordinator, at 11 State House Station, Augusta, Maine 04333-0011; 207-287-3707 (V); Maine Relay 711 (TTY); or ADA-CivilRights.DHHS@maine.gov. Civil rights complaints may also be filed with the U.S. Department of Health and Human Services, Office of Civil Rights, by phone at 800-368-1019 or 800-537-7697 (TDD); by mail to 200 Independence Avenue, SW, Room 509, HHS Building, Washington, D.C. 20201; or electronically at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Individuals who need auxiliary aids for effective communication in program and services of DHHS are invited to make their needs and preferences known to the ADA/Civil Rights Coordinator. This notice is available in alternate formats, upon request.

Form J - Ryan White Part B Program Copay Reimbursement Application



Date: _____

1. Client Information

Name: _____ Ryan White ID: DHS _____

2. Request Information

Make check payable to: _____

Total amount requested: \$ _____

Address for payment:

Account number (if applicable): _____

3. Attachments

Please attach the itemized pharmacy receipt with the medication name, prescription number, date filled, and cost per drug. This is the receipt that is usually stapled to the bag of medication. Receipts must be dated within the last 90 days.

4. Client Agreement

I understand that any refunds for payments made by the Ryan White Part B Program must be returned to the Ryan White Part B Program. All information I shared on this form is true.

Printed Name

Signature

Date

Office use only:

Date Received:

Date Complete:

Date Entered:

End date:

Approved. Not approved. Reason:

Staff initials: