



Nevada Ryan White Parts ABCD Common Guidance Document Primer: Survey of Existing Insurance Coverage

SCOPE OF COVERAGE

Directly applicable to all Ryan White Eligibility and Enrollment funded service providers and the AIDS Drug Assistance Program (ADAP) service provider.

PURPOSE OF PRIMER

In order to assist providers to understand how and when to use Common Guidance Document (CGD) 16-10 Survey of Existing Insurance Coverage.

BACKGROUND

Common Guidance Document (CGD) 16-10 Survey of Existing Insurance Coverage is a required document of the Annual Enrollment packet and with the Recertification Enrollment packet, if the client indicates a change in insurance status on the Six Month Self-Attestation Form (CGD 15-46).

WHEN TO USE CGD 16-10

CGD 16-10 must be attached to an ADAP referral if the client is requesting an ADAP assistance program, such as health insurance premium, copayment, or medication assistance. Access to Healthcare Network (AHN) will review the attached CDG 16-10 and will contact the client to collect necessary insurance documentation (if it was not provided by the referring eligibility agency), and if needed, AHN will assist the client in benefits enrollment. Any agency may assist the client with Medicaid enrollment.

HOW TO USE CGD 16-10

The eligibility agency will assist the client with the completion of CGD 16-10. The client's name, date of birth, signature, and date must be filled-in. The eligibility agency should explain available ADAP programs to the client, screen the client for desired services, and then answer the question, "*Is health insurance or prescription assistance being requested?*" If health insurance or prescription assistance is not being requested, then CDG 16-10 is still required to be completed for Ryan White eligibility documentation but a referral is not required to be sent to AHN through the ADAP Domain.

The client should read each insurance coverage statement on CGD 16-10 and indicate if they *do* or *do not* have each type of health insurance. The client may indicate they have more than one type of health insurance or indicate they do not have any of the health insurance options (considered uninsured).

If the client is uninsured, the client should be advised that they would be referred for health insurance assistance, either to the Federally Facilitated Marketplace (Nevada Health Link), to Medicaid, or to Medicare, unless the client chooses to decline or "opt-out" of coverage.

If the client believes that they are "*likely not eligible*" for health insurance coverage or refuses to apply for health insurance coverage through the Marketplace or Medicaid, the client may decline to apply for health insurance coverage. To decline Marketplace or Medicaid coverage, the client must indicate their intent to decline by answering statement 2b to decline for Marketplace coverage or 7b to decline Medicaid coverage. Only clients who would be referred to the Marketplace because they are currently uninsured and have an income between 139% and 400% of the Federal Poverty Level need to answer 2b. Only clients who would be referred to Medicaid because they are currently uninsured and have an income at or below 138% of the Federal Poverty Level need to answer 2b.

For uninsured clients, the eligibility agency should screen the client for Federal Poverty Level (FPL) and assist the client to understand if their income level would warrant a referral to the Marketplace or Medicaid.