MN Drug Co-pay Reimbursement program
(DCR program)
2577 Territorial Rd
St. Paul, MN 55114
(612) 331-7733 - Metro Area
(800) 565-9028 - Greater MN
(612) 341-3804 - Fax epc@rainbowhealth.org email
See attached guidelines and eligibility criteria form

EPC Client # _____
PE Client # _____
(for office use only)

Prior forms no longer valid
_____***This application is only for **MN Drug Co-pay Reimbursement**

Please complete all information requested on this form. Incomplete applications may not be processed. This application can only be used when applying for the MN Drug Co-pay Reimbursement (DCR) program.

First Name | Middle Name | Last Name

Address | Apt | County YES ☐ NO ☐

City | State | Zip *(Required)* | OK to Send Mail

Phone (s) include area code | **Birthdate (MM/DD/YY)**

Case Manager/Social Worker: _____ **Phone #:** _____
I authorize my Case Manager/Social Worker/HIV provider to exchange information with EPCEA staff regarding financial assistance: _____ (initial)

Expected Annual household gross income (wages, SSI, SSDI, GA, etc): $_____

Number of people legally dependent on this income (including yourself): _____

You must provide documentation of proof of Program HH and MA, MA-EPD, or MNCare eligibility.
Program HH and insurance verification is needed for every month of assistance requested. A MN-IT'S print out verifying your active enrollment of Program HH and Medical Assistance (MA), Medical Assistance for Employed Persons with Disability (MN-EPD) or MinnesotaCare is required for each month of prescription (Rx) co-pay reimbursement.

Living Situation: ☐ Stable/Permanent ☐ Temporary ☐ Unstable

Race *(Select one or more)*:
☐ White ☐ African American/Black ☐ American Indian ☐ Native Hawaiian ☐ Alaska Native ☐ Pacific Islander ☐ Asian

Ethnicity (Select one):
☐ Hispanic/Latino ☐ Not Hispanic/Latino

Gender Assigned at Birth (Select one):
☐ Male ☐ Female

Current Gender Identity (Select one):
☐ Male ☐ Female ☐ Transgender male to female ☐ Transgender female to male ☐ Nonbinary

Sexual Orientation (Select one):
☐ Lesbian/gay/queer ☐ Straight/heterosexual ☐ Bisexual ☐ Other _____

When was your last visit to your HIV doctor/lab work?: (Doctor visit information is needed every 6 months)
Month/Day/Year of appointment: _____ What was your last viral suppression data results:_____

Country of Birth: ☐ USA ☐ Other: Specify_____ ☐ Refused ☐ Unknown

Born in Minnesota: ☐ Yes ☐ No **If no, date you moved to Minnesota?** _____

This program was made possible with funding provided by the Minnesota Department of Human Services (DHS).

By completing and signing this application I acknowledge that I have read and understand the program guidelines and consent to receive services from Rainbow Health. I also acknowledge I have received of a copy of the Rainbow Health Client Bill of Rights, Grievance Procedure and Data Practices Notice. I acknowledge that the information provided in this application is true and I authorize Rainbow Health to verify the accuracy of the information as necessary.

_____ _____
Signature Date

2022-2023 Guidelines for
MN Drug Co-pay Reimbursement (DCR) program
2577 Territorial Rd
St. Paul, MN 55114
epc@rainbowhealth.org

612-331-7733
1-800-565-9028 (Toll free)
612-341-3804 (Fax)

The MN Drug Co-pay Reimbursement program is available for low-income HIV-positive Minnesotans who are on Program HH, as well as Medicaid (Medical Assistance – MA & MA-EPD) or MNCare. Please read these guidelines carefully. **Failure to complete the application or provide correct documentation will result in a delay in meeting your prescription reimbursement need**.

Program funding year is July 1, 2022 – June 30, 2022. This is a limited time funded program, but may be extended.

Eligible individuals may receive reimbursement assistance for the out of pocket cost of prescription (Rx) co-pays that they have incurred back to January 1, 2018.

Only a MN-ITS printout proving enrollment in Program HH can and will be used as HIV, income, residency verification as well as prove of active status on MA, MA-EPD or MNCare for insurance verification for the DRC program.

A complete application includes:

1. A completed **DCR application**. A new application must be completed for each program year (July 1 – June 30). If you request assistance more than once during the program year and have a current application on file, you do not need to complete another application for additional requests.
2. **Proof of eligibility** requirements are that a client must provide proof that they were on Program HH, as well as that they were on Medical Assistance (MA or MA-EPD) or MinnesotaCare at the time of the prescription co-pay out of pocket expense incurred. A MN-ITS printout indicating that you were enrolled in Program HH and on Medical Assistance (MA or MA-EPD) or MinnesotaCare on the date of the Rx co-pay purchase will meet these eligibility requirements and must be submitted and verified for each prescription co-pay reimbursement request. MN-ITS printouts can be obtained from your HIV provider or the MN Drug Co-pay Reimbursement (DCR) program staff.
3. **You must submit** a copy of the receipt or receipts of the prescription co-pay's you paid for out of pocket to be reimbursed for those expenses. A ledger from a pharmacy showing the out of pocket prescription co-pay expenses that you have incurred will also work as proof for reimbursement.

Procedure

Completion of a DCR application is required. Please submit proof of eligibility of enrollment in Program HH and on Medical Assistance (MA or MA-EPD) or MinnesotaCare on the date of the Rx co-pay purchase and must be submitted and verified for each prescription co-pay reimbursement request. Provide proof of out of pocket prescription co-pay expenses which can go back to January 1, 2018. A reimbursement check for the out of pocket prescription co-pay expenses will be sent directly to the client with 30-45 days of the reimbursement request submission.

The MN Drug Co-pay Reimbursement (DCR) program will make assistance payments directly to the client via check only for their out of pocket prescription co-pay expenses upon proof provided of such expenses. *Not able to reimburse a client for prescription co-pays paid by another agency/fund or that were written off by the pharmacy.*

To qualify for assistance, applicants must meet all eligibility requirements. **This service is funded by the Department of Human Services (DHS).**

PLEASE NOTE:
Please call our voicemail and leave a detailed message if you have questions. We will usually return your call within one (1) working business day. It can take up to 30-45 business days to process your prescription co-pay reimbursement request.

In the event of a program change, a notice will be sent to providers and the EPC voicemail will be updated to communicate the changes.

AUTHORIZATION TO EXCHANGE INFORMATION

I hereby authorize _____ at Rainbow Health to exchange information regarding:
(Name)

_____ _____ with
(Name) (Date of Birth)

_____ _____
(Organization /Individual) (Phone Number)

_____
(Address)

NOTE: CLIENT TO INITIAL EACH ITEM INDICATING AUTHORIZATION OR WRITE "N/A" IF NOT APPLICABLE

Purpose: To provide and coordinate services including:

- ☐ Verification of diagnosis
- ☐ Medical information related to date of diagnosis/information regarding ongoing medical care
- ☐ Services provided by Rainbow Health
- ☐ Psycho-social factors including, but not limited to, housing, financial status, hospitalizations, home care needs and alcohol and drug use
- ☐ Medical history
- ☐ Chemical health assessment, diagnosis and recommendations
- ☐ Mental health/psychological history
- ☐ Program eligibility verification
- ☐ Coordination of Care

Other information to include:

I understand that this information will be kept in a confidential manner by Rainbow Health staff and trained volunteers.
I have been informed of my right to refuse to allow Rainbow Health to exchange this information.
I understand that I may revoke this consent upon written notice. The revocation will be effective the day it is received by the staff named on this release or his/her successor. I understand that information shared prior to revocation can't be retracted.
I understand that when health information is released the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws.
I understand a photocopy or fax of this form is the same as the original.
I understand I may have a copy of this form after I have signed it.
I understand that information may be exchanged via phone, fax, email or a meeting with provider.
I understand that the consent will automatically expire within one year after the date of my signature below, if an earlier date is not specified.

_____
Name (Please print)

_____ _____
Signature Date

This document is available in **alternate formats** upon request.

DATA PRACTICES NOTICE

This notice is given and/or reviewed with all Rainbow Health clients. For the purposes of this document, clients are defined as those persons receiving reportable services including AIDSLine Quick Connect, case management, CLEAR, ARTAS Linkage, Peer Support, transportation, housing services, legal services, benefits counseling, chemical health services, Every Penny Counts Emergency Assistance, Positive Link/HERR Support, PrEP Navigation and other support services.

As a client of Rainbow Health certain laws including the right to privacy protect you. The Minnesota Government Data Practices Act provides you with rights about data obtained from you. The data we collect at Rainbow Health is, in nearly all cases, considered private data, which means you have access to it. Rainbow Health is aware of the sensitive and private nature of much of the information that is shared between clients and Rainbow Health staff. Rainbow Health as an agency, is committed to maintaining and protecting your confidentiality.

Why Rainbow Health Collects Data

- To assess your individual situation and coordinate services for you. These services may be at Rainbow Health or they may be services you receive from other agencies;
- To assess the effectiveness of Rainbow Health's services;
- To verify to funding sources that Rainbow Health is providing services and the outcome of those services;
- To determine your eligibility for services offered by Rainbow Health and other agencies;
- To make appropriate referrals.

Information about you may be exchanged among Rainbow Health staff and volunteers as needed to coordinate services for you. Additionally, client records may be reviewed for the following reasons:

- Supervisors, agency attorneys or consultants to make sure you are receiving the best possible service;

Clients receiving services funded in whole or part through the Ryan White program will have demographic data about them (including: name, date of birth, race, ethnicity, gender, zip code, income level, insurance and housing status, HIV/AIDS diagnosis dates and related medical information) sent to the Minnesota Department of Health (MDH). Additionally, the Minnesota Department of Human Services and Hennepin County Ryan White Program will have access to information sufficient to carry out payment, treatment and operations as specified by the HIV/AIDS Bureau of the U.S. Department of Health & Human Services Health Resource and Service Administration (HRSA). These organizations maintain this information in a confidential manner and do not share your name with any other entities.

Right to Refuse and Consequences of Refusal

You have the right at any time to refuse to share information about yourself with Rainbow Health staff. Generally this will not affect the services you are receiving. However, in some cases, there is the possibility that Rainbow Health will be unable to provide some type of service to you unless we have certain information. Rainbow Health staff will let you know if your refusal to share information will affect the services that can be provided.

Rainbow Health provides information to agencies and government offices that provide funding to Rainbow Health. The Minnesota Department of Health HIV/STD Services Division, federal and state program compliance auditors, the Minnesota Department of Human Services HIV/AIDS Division Programs, Housing and Urban Development (HUD), Hennepin County Adult Services, Hennepin County Public Health and Human Services, the Minnesota Housing Finance Agency and the City of Minneapolis, Centers for Disease Control and other persons or entities authorized by law to collect data may also review client records to monitor the services provided by Rainbow Health. The same law that gives you privacy prohibits these persons or entities from releasing information about you once they have received it.

Rainbow Health staff are mandated reporters meaning there are circumstances when they are required to report suspected child abuse or neglect, threats to others or self, or suspected abuse or neglect of vulnerable adults to social services or law enforcement. Other than these circumstances and as outlined above, Rainbow Health cannot use or release information without your express written or verbal permission.

My signature below means that I have read this document and have also been offered a copy of this information.

_____ _____

Client Signature Date

_____ (Staff initial and date if no client signature)

This document is available in alternate formats upon request.

RAINBOW HEALTH

Rainbow Health Client Bill of Rights

As a client of Rainbow Health, you have the right to:

1. Be treated with consideration and respect by staff, volunteers and interns of Rainbow Health. You have the responsibility to treat Rainbow Health staff, volunteers and interns in a similar manner.

2. Quality services without discrimination regardless of race, ethnicity, national origin, religion, age, sexual orientation, gender or disability.

3. Confidentiality of information we collect about you. No identifying information about you will be shared outside of Rainbow Health without a release of information dated and signed by you listing individuals and agencies with whom you have agreed to have us share information by fax, phone, email or meeting and that all releases will be renewed if needed, on an annual basis. **Any exceptions are outlined in the data practices guidelines.** All records and files pertaining to the services you receive at Rainbow Health will be kept in locked filing cabinets and/or secure
computer files when not in use.

4. Review all private information in your file and obtain a copy of this information. If you request a copy, the request must be in writing and signed by you. We will not give or send a copy of your file to any other person without a signed release from you except if we receive a valid court order.

5. Expect reasonable assistance to overcome language, cultural, physical or communication barriers. This means for example, that upon request Rainbow Health will provide interpreters for the deaf and for those who do not speak English.

6. Prompt and reasonable response to your questions and requests.

7. Participate in developing your service plan including developing service goals that meet your needs.

8. Prompt information on how to make complaints and pursue a grievance if you are having difficulties or are dissatisfied with the services you are receiving.

9. Refuse services or recommended services and to discontinue services at JustUs Health.Rainbow Health

10. Receive timely notice and explanation of changes in program guidelines including changes in eligibility criteria and funding availability.

If you have questions about Rainbow Health services, or would like to make a suggestion, you may do so with your service provider, the program manager, or the director of programs.

Specific Rainbow Health programs or services may have additional rights and responsibilities that will be made available to you upon entry into the program.

As a provider of services, Rainbow Health will:

- Determine your eligibility to receive and to continue services.
- Assign the staff, volunteers or interns who will work with you.

RAINBOW HEALTH

Rainbow Health
GRIEVANCE PROCEDURE

1. Any person receiving services from Rainbow Health may voice comments, concerns, or grievances directly to the staff person they are working with or to that staff person's supervisor.

2. If your comment, concern or grievance was not addressed to your satisfaction, you may arrange a meeting with or submit a written statement to the Program Director of the service your grievance is connected to. The Rainbow Health staff person you talked with will provide the contact information including the name, address and phone number of this Director. Your written statement or request for a meeting must be received within two weeks of the date you last addressed this issue or concern with the staff person or their supervisor

3. You will receive a written response within 30 days after we with you receive your written statement. This written decision is the final decision of Rainbow Health.

4. Some programs offered by Rainbow Health are funded through contracts with various government agencies that will also accept your grievance if your concern or grievance has not been settled to your satisfaction. Information with the appropriate name and contact information at each agency is available upon request or will be mailed to you within one working day of your written or verbal request for it.

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