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¦ LOCAL COMMISSIONERS MEMORANDUM ¦
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DSS-4037EL (Rev. 9/89)

Transmittal No: 93 LCM-169

Date: November 30, 1993

Division: Health & Long Term Care

TO: Local District Commissioners

SUBJECT: AIDS Health Insurance Program (AHIP)

ATTACHMENTS: Attachment I: AHIP Contact Notification Form (available on-line)
Attachment II: Revision to Attachment II of 93 ADM-28 (available on-line)

The purpose of this release is to inform you that Fred Perkins from the Bureau of Eligibility and Resources has been designated as the new general contact for the AIDS Health Insurance Program (AHIP).

The most current release describing the AHIP Program is 93 ADM-28; AIDS: Health Insurance Continuation Program for Persons with AIDS (AIDS Health Insurance Program [AHIP]). In that release, Bobbi Krusik is listed as the general contact for the program. Ms. Krusik has agreed to assist Mr. Perkins during the initial transition of this program but all questions should be directed first to Mr. Perkins.

Please direct all general questions and all of your quarterly reports to Mr. Perkins. A revised Attachment II of 93 ADM-28 is enclosed for your information. Please forward this revision to your AHIP contact.

In 93 ADM-28 districts were notified about reporting changes; "Reports must be submitted to the NYSDSS on a quarterly rather than a semi-annual basis". To date, there are still a number of local districts which have not identified a person in the agency who will be responsible for completing these reports and submitting them to the Department. Please complete Attachment 1, which will identify for us the person in your agency and that person's phone number who will be responsible for completing the AHIP quarterly reports.

Thank you for your cooperation. Please call Fred Perkins if you have any questions at (518) 486-5870 or 1 (800) 342-3715 extension 6-5870, User ID 89D210.

Sue Kelly
Deputy Commissioner
Division of Health & Long Term Care

ATTACHMENT I

Local Social Services Department
AHIP Contact Notification Form

Please complete all fields identified on this form and submit completed form to:

Mr. Frederick M. Perkins
Bureau of Eligibility and Resources
Policy Unit 2
PO Box 1935
Albany, New York 12201

County Code_____ County Name_____

Name of person responsible for completing and forwarding to the Derpartment the AHIP Quarterly Reports:_____

Title of AHIP Contact:_____

Phone # of AHIP Contact: (_____)_____

ATTACHMENT II

AIDS HEALTH INSURANCE PROGRAM
QUARTERLY REPORT

1. Social Services District:_____

2. Name and Title of Person Completing Report:_____

_____

3. Telephone Number: (_____)_____-_____

4. Reporting Period: From: ___/___/___ To: ___/___/___

5. Did you have any clients in the AIDS Health Insurance Program during this reporting period?

_____No. END OF REPORT

_____Yes. GO TO QUESTION 6

6. Were any health insurance premium payments made for these clients during the reporting period?

_____No. END OF REPORT

_____Yes. GO TO QUESTION 7

7. What was the total dollar amount of these payments? $_____

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SUBMIT THIS REPORT ACCORDING TO THE FOLLOWING SCHEDULE:

Reporting Period	Due Date
January 1-March 31	May 15
April 1-June 30	August 15
July 1-September 30	November 15
October 1-December 31	February 15 of the following year

Submit each report manually or electronically to:

Frederick M. Perkins
NYS Department of Social Services
Bureau of Eligibility and Resources
PO Box 1935
ALbany, NY 12201
(518) 486-5870 or 1-800-342-3715 extension 6-5870
User ID: 89D210