General Information

The N.Y.S. Department of Health, AIDS Institute offers four programs to provide access to health care (ADAP, Primary Care, Home Care, and APIC) for New York State residents with HIV infection who are uninsured or underinsured. The four programs use the same application form and enrollment process, additional forms are required for Home Care and APIC.

The AIDS Drug Assistance Program (ADAP) pays for medications for the treatment of HIV/AIDS and opportunistic infections. The drugs paid for by ADAP can help people with HIV/AIDS live longer and treat the symptoms of HIV infection. ADAP can help people with no insurance, partial insurance, Medicaid Spend-down / Surplus or Medicare Part D.

ADAP Plus (Primary Care) pays for primary care services at participating clinics, hospitals, laboratory providers, and private doctors offices. The services include ambulatory care for medical evaluation, early intervention and ongoing treatment.

The HIV Home Care Program pays for home care services for chronically medically dependent individuals as ordered by their doctor. The program covers home health aide services, intravenous therapy administration and supplies and durable medical equipment provided through enrolled home health care agencies.

ADAP Plus Insurance Continuation (APIC) pays for cost effective health insurance premiums for eligible participants with health insurance including, COBRA, Medicare Part D and private or employer sponsored policies.

HIV Uninsured Care Programs Confidentiality Statement

Under New York State Law, HIV related information provided to the Uninsured Care Programs is kept strictly confidential. Such information (i.e. that you are a participant) may be given to those parties necessary for the proper administration of the Programs. These are individuals and organizations with whom the Programs need to discuss your application and/or participation in order to determine eligibility, pay for services or drugs covered under the Programs, or properly account for the funds spent. Program staff is aware of a participant’s need for confidentiality and privacy, and will discuss personal information only as strictly necessary for the administration of the Programs.

To provide you with an understanding of the issue of confidentiality and the conditions of participation in the Programs, the following examples are provided:

• The Programs will NOT contact your employer, landlord, family, friends, neighbors, or anyone else without direct consent from you; whether directly related to your application or participation in the Programs.

Application Instructions

Eligibility is based on financial and medical need. Along with a complete application, documentation of residency, income and assets is required. A separate medical application must be submitted by your doctor.

Applications submitted with all required documentation are processed within two weeks. Incomplete applications and applications without supporting documentation will delay receipt of your enrollment card and vital program information.

When you are approved, you will get an Eligibility Card and instructions on how to use it. You must present this card and a prescription at a participating pharmacy to receive covered medications at no charge. Show your card to participating health care providers to receive covered medical services at no charge. If you need them, you will receive home care services from an enrolled home health care agency at no charge ($30,000 maximum life-time benefit).
A. Applicant Information

Name
List your full name, social security number and date of birth. If there is another name you are known by, put that in the space provided and tell us the name you want printed on your card. Include your complete address.

Address
Proof of New York State residency is required. Residency can be documented with a copy of ONE of the following (showing your name and address). If you have a PO Box where you receive your mail you must include information documenting your physical address to document New York State residency. If you live with someone and have none of the items below in your name, we will need proof of their residency and a letter stating that you live with them:
- Current lease
- Current driver's license
- Current voter registration card
- Current Notice of Decision from Medicaid
- Fuel/utility bill (past 90 days)
- Phone bill (past 90 days)
- Rent receipt (past 90 days)
- Pay stub or bank statement with your name and address (past 90 days)

Sex/Race/Ethnicity/Language
Please check your sex, race, ethnicity and language preference.

B. Living Arrangement

Household Members
List all household members. Anyone who is legally responsible to or for you is considered a household member. This includes a spouse and any children under 21 years old or parent and siblings if you are under 21 years old.

C. Income

Financial Eligibility
Financial eligibility is based on 435% of the Federal Poverty Level (FPL): FPL varies based on household size and is updated annually. Financial eligibility is calculated on the gross income available to the household excluding Medicare and Social Security withholding and the cost of health care coverage paid by the applicant.

Income Source
Check all sources of income for you and all household members. This is income only for household members with whom you have a legally responsible relationship (for example, spouse or child but not uncle, cousin or roommate). For each source you checked, indicate the current balance/value and whether it is your asset or a household member’s.

Proof of Income is required. Provide complete income documentation for each source of income checked.

For Wage Earners
Income should be documented by copies of pay stubs for the past 30 days. The paystub must show the year-to-date earnings, hours worked, all deductions and the dates covered by the paystub. If you cannot get a paystub, send us a notarized letter from your employer showing gross pay for the past 30 days along with a copy of your most recent income tax return. (The letter does not need to be addressed to the Programs. A letter addressed “to whom it may concern” is sufficient.)

Self-employed Individuals
Provide business records for the three months prior to application indicating type of business, gross income, net income, and your most recent year income tax return. A notarized statement from you of projected current annual income must also be included.

D. Liquid Assets

Households cannot have liquid assets greater than $25,000. Liquid assets are cash, savings, stocks, bonds, etc. They do not include your car, home or federally recognized retirement accounts.

Asset Source
Check all sources of assets for you and all household members. This is only for household members with whom you have a legally responsible relationship (for example, spouse or child but not uncle, cousin or roommate). For each source you checked, indicate the current balance/value and whether it is your asset or a household member’s.

Proof of assets is required. People with liquid assets must send copies of the most recent statements showing the cash value and the amount of interest/dividends received.

E. Health Coverage

The Programs can help people who have other health coverage and are having difficulty meeting their deductibles, co-payments, Medicaid Spenddown/Surplus or other out of pocket costs. Include a copy of the front and back of all other health coverage cards.

Medicaid/Family Health Plus
Indicate your Medicaid Status or whether you have applied for Family Health Plus. If you have a Medicaid Spend-down/Surplus write the amount in the space provided.

Medicare
Indicate if you have Medicare and if so, what type(s), A, B, C or D.

Health Insurance
Be sure to answer all questions regarding health insurance. If you are having trouble making your health care premium payments please call 1-800.542.2437 or complete the APIC application (form number DOH 2794c) which can be found at http://www.health.state.ny.us/diseases/aids/resources/adap/index.htm

F. Alternate Contacts(s) and Signature

In order for Program staff to speak to someone on your behalf about your application, you must list them here. Please read the confidentiality statement that describes who we may contact regarding your application and enrollment.

Carefully read the Certification Statement then sign and date the application. We cannot process an application that is not signed. Make a copy of the application and all documentation for your records.

Problems or Questions
If you have problems filling out the application or have questions about the HIV Uninsured Care Programs or any required documentation, please call toll-free: 1-800-542-2437 or review the “Frequently Asked Questions” document found at http://www.health.state.ny.us/diseases/aids/resources/adap/index.htm
HIV Uninsured Care Programs Application

This application is used to determine eligibility for the AIDS Drug Assistance Program (ADAP), ADAP Plus (primary care), HIV Home Care and the ADAP Plus Insurance Continuation (APIC). Additional paperwork is needed for Homecare and APIC. If you have any questions about the programs or completing this application, contact our confidential hotline at 1-800-542-2437.

PLEASE COMPLETE THIS APPLICATION FULLY AND PRINT CLEARLY

A. Applicant Information

Last Name: __________________________ First Name: __________________________ MI: __________ Date of Birth: __________/_________/__________

Other Name(s) Used: __________________________ Social Security Number: __________ – __________ – __________

Address (Proof of Residency is Required)

Street: __________________________ Apt #: __________ City: __________________________ State: __________ Zip Code: __________

Can program information be sent to the address listed? □ Yes □ No  If no, attach an explanation with an alternate address.

Phone

Primary: (______)–________ Secondary: (______)–________ Can we leave a message? □ Yes □ No

Sex □ Male □ Female □ Transgender/ Transsexual

Race □ White □ Black/African American □ Asian □ Hawaiian / Pacific Islander □ Native American / Alaskan □ More Than One Race

Other __________________________

Ethnicity □ Hispanic □ Non-Hispanic

Language Preference □ English □ Spanish □ Other __________________________

Marital Status □ Single, Widowed, Divorced □ Married, Living Together □ Married, Living Apart

B. Living Arrangement

□ Live Alone □ Live With Others (Complete Below) □ Homeless/Shelter □ Corrections Release

Household Member’s Name*  Sex  Date of Birth  Relationship  Lives with you

1. __________________________ □ M □ F □ T  / /  □ Yes □ No
2. __________________________ □ M □ F □ T  / /  □ Yes □ No
3. __________________________ □ M □ F □ T  / /  □ Yes □ No
4. __________________________ □ M □ F □ T  / /  □ Yes □ No

* If you would like us to speak with any listed household member please add their name as an alternate contact on page 2.

C. Income – Applicant and Household Members (proof of income is required)

Income Source (Check all that apply):

□ Salary/Wages: □ FT □ PT □ New York City Employee □ Public Assistance □ Veteran’s Benefits □ No Income, Supported by others
□ Public Assistance □ SSI (Supplemental Security Income) □ Allimony / Child Support □ No Income, Living off Savings
□ Self Employed □ SSD (Social Security Disability) □ Interest / Dividends / Royalties □ Other:
□ Unemployment □ Social Security Retirement □ Rental Property
□ Worker’s Compensation □ Pension

For all checked above, please indicate:

Income Source  Gross Amount  How Often  Recipient  Start date

1. __________________________ $___________ □ Weekly □ Bi-weekly □ Applicant □ Household Member  / /
2. __________________________ $___________ □ Weekly □ Bi-weekly □ Applicant □ Household Member  / /
3. __________________________ $___________ □ Weekly □ Bi-weekly □ Applicant □ Household Member  / /

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D. Liquid Assets (proof of liquid assets is required)

Asset Source (Check all that apply)

☐ Checking Account  ☐ Savings Account  ☐ CDs  ☐ Stocks/Bonds/Mutual Funds  ☐ Annuities or Trusts  ☐ Interest

For all checked above, please indicate:

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<tr>
<th>Asset Source</th>
<th>Balance/Value</th>
<th>Recipient</th>
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|              |              | ☐ Applicant | ☐ Household Member | ☐ Joint
|              |              | ☐ Applicant | ☐ Household Member | ☐ Joint
|              |              | ☐ Applicant | ☐ Household Member | ☐ Joint

E. Healthcare Coverage

Do you have other healthcare coverage? (Private Policy, HMO, Union, Retirement, or Other Health Plan)  ☐ Yes  ☐ No

Do you pay health insurance premiums?  ☐ Yes  ☐ No

If Yes to either, how much are the payments? $ __________________________ How often are the payments made? __________________________

If No to the above, is health insurance offered through your job/employer?  ☐ Yes  ☐ No

Call the program at 1-800-542-2437 to find out how ADAP can help with your health insurance payments.

If you have health insurance, send a copy of the front and back of your cards and complete below:

Health Insurance Company Name: __________________________ Effective Date on Policy: / /
Address: __________________________ Policy Number: __________________________
City: __________________________ State: _______ Zip Code: __________________________
Member Services Contact (If known): __________________________ Member Services Phone: (____) –

Medicaid/Family Health Plus

Have you applied?  ☐ Yes  ☐ No

If Yes, what was the outcome?  ☐ Pending  ☐ Approved – Medicaid #: __________________________  ☐ Spend-down (if applicable) – Amount: $ __________________________
☐ Denied – Reason: __________________________

Medicare

Do you have Medicare?  ☐ Yes  ☐ No

If Yes, what type(s)?  ☐ A - Hospitalization  ☐ B - Primary Care  ☐ C - Medicare Advantage Plan  ☐ D - Prescription Drug

Do you pay premiums for Medicare Part D?  ☐ Yes  ☐ No

Do you have “extra help” for Medicare Part D?  ☐ Yes  ☐ No

If “No” please call our hotline to find out more about “extra help”

F. Alternate Contact(s) and Signature

By signing this application, I authorize the Uninsured Care Programs to speak with the following person(s) about my application (i.e., social worker, case manager, family member):

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
<th>Relationship</th>
<th>Phone Number</th>
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Certification Statement

I certify that all the information in this application is true and correct and that I am a New York State Resident. I understand the following:

This information is being given in connection with the receipt of federal funds by the State of New York. Program officials will verify the information on this form. Program officials may periodically verify my Medicaid status and bill Medicaid as necessary. If I deliberately misrepresent information on this application, I may be required to repay benefits provided to me and I may be prosecuted under applicable State & Federal Statutes.

I hereby apply for benefits under the Uninsured Care Programs and consent for my information to be used and disclosed as necessary for the purposes of my treatment, for payment of healthcare services, payment of healthcare premiums and for the healthcare operations of the Program.

Sign and Date this Form

______________________________ __________________________
Signature of Applicant (or legal guardian if applicant is a minor) Date

Keep a copy of this form for your records and mail the original form and all documentation to:

Uninsured Care Programs, Empire Station, PO Box 2052, Albany, NY 12220-0052

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