AIDS Drug Assistance Program Enrollment Application

Phone: 1 (844) 421-7050 ADAP Fax: 1 (844) 421-8008

Required fields will be denoted with an asterisk (*)

Required fields, if applicable will be denoted by two asterisks (**)

Client ID _____

Type of application*: ☐ Initial ☐ Update ☐ Re-enroll ☐ Re-Cert/ S V F with Changes

Section 1 Profile

First Name* _____ Middle Initial _____ Last Name* _____

Date of Birth* _____ Social Security Number _____

Residential Address _____ Apartment Number _____

City* _____ State* _____ Zip* _____ County _____

☐ Homeless

May we send mail to this residential address?*

☐ Yes ☐ No, use mailing address ☐ No, use enrollment site

Mailing address* _____ Apartment Number _____

City* _____ State* _____ Zip* _____ County _____

Phone Number _____

May we contact you at this phone number?*

☐ Yes ☐ No ☐ N/A

Email address _____

May we contact you at this email address?*

☐ Yes ☐ No ☐ N/A

Section 2 Demographics

What is your sex at birth?* ☐ Male ☐ Female ☐ Unknown

Are you pregnant?* ☐ Yes ☐ No

What is your gender?*

☐ Male ☐ Female ☐ Transgender, Male to Female

☐ Transgender, Female to Male ☐ Transgender, Unknown ☐ Unknown

What is your sexual orientation?*

☐ Straight or heterosexual ☐ Lesbian, gay, or homosexual ☐ Bisexual

☐ Other, please specify _____

☐ Don't know ☐ Choose not to disclose

What is your ethnicity?* ☐ Hispanic (see E1) ☐ Non-Hispanic

E1.If Hispanic, how would you identify?** (Check all that apply)

☐ Mexican, Mexican American, Chicano/Chicana ☐ Puerto Rican ☐ Cuban

☐ Spanish, Portuguese, Cape Verdean ☐ Other Hispanic ☐ Not Applicable

What is your race? (Check all that apply)*

☐ White ☐ Black or African American ☐ Asian (See R1)

☐ Native Hawaiian/ Pacific Islander (See R2) ☐ American Indian ☐ Decline to Provide

R1. If Asian, how would you identify (Check all that apply)**

☐ Asian Indian ☐ Bangladeshi ☐ Burmese ☐ Cambodian ☐ Chinese

☐ Filipino ☐ Hmong ☐ Indonesian ☐ Japanese ☐ Korean

☐ Malaysian ☐ Pakistani ☐ Singaporean ☐ Sri Lankan ☐ Taiwanese

☐ Vietnamese ☐ Laotian ☐ Thai ☐ Other Asian

R2. If Native Hawaiian/ Pacific Islander, how would you identify (Check all that apply)**

☐ Fijian ☐ Guamanian or Chamorro ☐ Native Hawaiian

☐ Samoan ☐ Tongan ☐ Other Pacific Islander

Section 3 Clinical

What is your HIV status?* ☐ HIV Positive, not AIDS ☐ CDC-defined AIDS

Viral Load _____ Date of Viral Load _____

C D 4 Count _____ Date of C D 4 Count _____

Section 4 Household

What is your current status?* ☐ Single ☐ Married ☐ Legally Separated ☐ Divorce ☐ In a Domestic Partnership

Household size (Persons including yourself)* _____

Annual Household Income* _____

Year for Household Income (Current or previous year)* _____

Section 5 Health Coverage

Medi-Cal Coverage

Are you enrolled in Medi-Cal?*

☐ Yes, I am enrolled ☐ I applied, but was denied ☐ No, I was dis-enrolled

☐ I am still awaiting a decision about my Medi-Cal eligibility ☐ No, I never applied

☐ I do not know

If "Yes, I am enrolled" is selected, please answer the following questions.**

What type of Medi-Cal are you enrolled in?**

☐ Medi-Cal Expansion ☐ Standard Medi-Cal ☐ I do not know

If "Medi-Cal Expansion" is selected, please answer the following questions.**

Effective Start Date _____ Effective End Date _____

Medi-Cal Benefits Identification Card (BIC) Number _____

If "Standard Medi-Cal" is selected please answer the following questions**

Effective Start Date _____ Effective End Date _____

Medi-Cal Benefits Identification Card (BIC) Number _____

Do you have a Medi-Cal Share of Cost (SOC)? ☐ Yes ☐ No ☐ I don't know

If “No, I was dis-enrolled” is selected, please answer the following questions.**

What type of Medi-Cal were you dis-enrolled in?**

☐ Medi-Cal Expansion ☐ Standard Medi-Cal

If “Medi-Cal Expansion” is selected, please answer the following questions.**

Effective Start Date _____ Effective End Date _____

What type of dis-enrollment did you receive?**

☐ I have income at or above 138% Federal Poverty Level.

☐ I am Medicare eligible.

☐ I have excess assets.

☐ I am employed or able to work.

☐ I am receiving Unemployment Insurance (UI).

☐ I was denied within the past 12 months from Medi-Cal, Supplemental Security Income .

(SSI) or Social Security Disability Insurance (SSDI).

☐ Other

If “I am still awaiting a decision about my Medi-Cal eligibility” is selected, please answer the following questions**

Date you applied to Medi-Cal _____

Medicare Coverage

Are you eligible for Medicare?* ☐ Yes ☐ No

If “Yes” is selected, please answer the following questions.**

Are you enrolled in Medicare Part D Health Plan?

☐ Yes, I am enrolled ☐ No, I was dis-enrolled ☐ No, I have never applied

If “Yes, I am enrolled” or “No, I was dis-enrolled” is selected, please answer the following questions.**

Medicare Part D Plan Enrollment Start Date_____

Medicare Part D Plan Enrollment End Date _____

Private Insurance Coverage

Are you enrolled in private insurance?*

☐ Yes, I am enrolled ☐ No, I am not enrolled ☐ No, my plan was terminated

If "Yes, I am enrolled" or "No, I am not enrolled" is selected, please answer the following questions.**

What type of health insurance plan are you enrolled in? If your plan was terminated, what type of health insurance were you enrolled in?

☐ Health insurance plan obtained through Covered CA

☐ Private insurance plan obtained through health insurance provider or broker

☐ Health insurance plan through employer

☐ Private insurance through Spouse or Other

☐ Private Insurance through Veteran's Administrative Health Care (e.g. Tricare)

☐ COBRA or Cal-COBRA

☐ Other, please specify type of health insurance plan _____

Health Insurance Plan Name _____ Member ID _____

Plan Start Date _____ Plan End Date _____

Section 6 Insurance

Would you like assistance with your insurance premiums?*

☐ Yes, I would like assistance with my health insurance premiums.

☐ Yes, I would like assistance with my Medicare Part D premiums. If selected, Medicare Part D Premium Payment eligibility and payment start date will be determined using Medicare enrollment information from Section 5.

☐ No, I would not like assistance.

Notes

- The HIPP program must assist with the medical premium in order to assist with dental and vision premiums.
- The HIPP program does not assist with stand-alone vision plans. The vision premium must be included with the medical or dental health insurance billing statement premiums.
- Individuals with 100% Extra Help/Full Low Income Subsidy (LIS) are not eligible for the Medicare Part D Premium Payment Program.

If "Yes, I would like assistance with my health insurance premiums" is selected, please answer the following questions**

Medical

Health Insurance Payee Name?**

- ☐ Anthem Blue Cross
- ☐ Blue Shield of California
- ☐ Blue Shield of California Small Group
- ☐ Conexis
- ☐ Health Net
- ☐ Kaiser
- ☐ La Care and Local Initiative
- ☐ Molina Health Care of California
- ☐ Delta Dental of California
- ☐ Premier Access
- ☐ Other, please specify other health insurance payee name_____

Type of Policy**: ☐ Individual ☐ Family

What is your net premium amount? _____

Member ID/Subscriber ID Number _____

Account Number (if applicable) _____

Policy Number/ Group Number (if applicable) _____

How often is your premium due?

☐ Monthly ☐ Bi-Monthly ☐ Quarterly ☐ Annually

Plan Start Date _____ Plan End Date_____

Type of coverage:

☐ Covered CA ☐ Private ☐ COBRA ☐ Cal-COBRA ☐ Other

If "Covered CA" is selected, please answer the following questions**

What is your gross monthly premium amount?_____

What is the maximum Advanced Premium Tax Credit?_____

What is the maximum Advanced Premium Tax Credit amount you are taking?_____

What Covered CA metal did you select? ☐ Bronze ☐ Silver ☐ Gold ☐ Platinum

Dental

Yes, I would like to receive dental assistance. If checked, please answer the following questions below. **

Dental Insurance Payee Name?

- ☐ Anthem Blue Cross
- ☐ Blue Shield of California
- ☐ Blue Shield of California Small Group
- ☐ Conexis
- ☐ Health Net
- ☐ Kaiser
- ☐ La Care and Local Initiative
- ☐ Molina Health Care of California
- ☐ Delta Dental of California
- ☐ Premier Access
- ☐ Other, please specify other health insurance payee name_____

Type of Policy: ☐ Individual ☐ Family

What is your net premium amount?_____

Member ID/Subscriber ID Number_____

Account Number (if applicable)_____

Policy Number/ Group Number (if applicable) _____

How often is your premium due?

☐ Monthly ☐ Bi-Monthly ☐ Quarterly ☐ Annually

Plan Start Date _____ Plan End Date _____

Vision

Yes, I would like to receive vision assistance. If checked, please answer the following questions..**

Note: Standalone vision plans are not covered. Vision must be bundled with Medical or Dental for coverage.

Vision Insurance Payee Name?

- ☐ Anthem Blue Cross
- ☐ Blue Shield of California
- ☐ Blue Shield of California Small Group
- ☐ Conexis
- ☐ Health Net
- ☐ Kaiser
- ☐ La Care and Local Initiative
- ☐ Molina Health Care of California
- ☐ Delta Dental of California
- ☐ Premier Access
- ☐ Other, please specify other health insurance payee name_____

Type of Policy: ☐ Individual ☐ Family

How often is your premium due?

☐ Monthly ☐ Bi-Monthly ☐ Quarterly ☐ Annually

Plan Start Date _____ Plan End Date _____

Section 7 Read and Sign this Application

Temporary Access Period (TAP) Request

To request a temporary access period, the information below must be completed by the applicant/client who failed to provide the supporting eligibility documentation.

Please complete the application sections below:

☐ Proof of Identification

I will provide my ADAP Enrollment worker with identification.

☐ Proof of California Residency

I will provide proof of my California residency to my ADAP Enrollment worker.

☐ Diagnosis Form

MY HIV positive status qualifies me for the ADAP program. I will provide my ADAP enrollment worker with a completed Diagnosis Form, a letter from my physician, or lab values including a recent Viral Load and CD4, if applicable.

☐ Income

I will provide proof of my household income to my ADAP enrollment worker.

☐ Proof of Medi-Cal Determination

I will apply for, and provide proof to my ADAP enrollment worker of Medi-Cal determination.

By signing below, I hereby certify that the above information is factual, accurate, and complete. I understand that I have a temporary access period in which to provide the necessary documentation to substantiate my qualifying ADAP information as stated above and that failure to comply within the allotted temporary access period will result in my ineligibility until such proof is provided. I also understand that ADAP is permitted to request additional verification documentation if the submitted documentation appears to be inconsistent or incorrect. I agree to promptly notify the program of any changes in my income, residency and health coverage. I understand that failure to provide accurate information or deliberately omit information may result in suspension or termination of services and I may be held financially responsible for any covered services obtained.

_____

Applicant's or ADAP approved designated agent's signature

_____

Date

Section 7 Read and Sign Application Continued

Penal Code and California False Claims Act

ADAP clients who knowingly provide inaccurate or false documentation may be in violation of various Penal Code laws and the California False Claims Act.

By signing below, I agree to the best of my knowledge that I provided accurate and true information when applying for or submitting eligibility or claim information to ADAP.
Please note: Clients will also need to submit the Client Attestation Form, Consent Form, and all supporting documentation.

_____

Applicant's or ADAP approved designated agent's signature

_____

Date

Section 8 ADAP Enrollment Worker Information

Enrollment Worker Name* _____

Phone Number* _____ Email address* _____

Enrollment Site Name* _____

Enrollment Site Number* _____ County* _____