NEW YORK STATE DEPARTMENT OF HEALTH
AIDS Institute

Empire Station
P.O. Box 2052
Albany, NY 12220-0052
1-800-542-2437

Application & Instructions for the HIV Uninsured Care Programs

AIDS Drug Assistance Program (ADAP)
ADAP Plus (Primary Care)
HIV Home Care Program
ADAP Plus Insurance Continuation (APIC)

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.
- The Programs may contact your doctor or health care provider to get more information or clarify information required on the Medical Eligibility Form.
- The Programs will verify to a pharmacy, or to a health care provider that you are enrolled and pay for the covered services or drugs when your Program card, with your name and ID number, is shown to a pharmacy or health care provider.
- The Programs will discuss the application of individuals in prison with authorized employees of Parole or Corrections as needed to enroll in the Programs.

You may notify the Programs, in writing, of someone you want the Programs to contact if Program staff cannot contact you for more information (i.e. the social worker who is helping you to apply for the program).

The Uninsured Care Programs are the payer of last resort and will contact your health insurance company or other third party payer (i.e. drug manufacturer rebate program) who will reimburse ADAP for drugs provided to you under the Programs. This is necessary for ADAP to recover funds which can be used to expand the Programs to cover new drugs/services and more people living with HIV infection.

These conditions are from the date of your application until your termination from the Programs, including the time needed to complete any third party reimbursement procedures for therapeutic drugs or services provided by the Programs. You may terminate your enrollment in the Programs in writing at any time.

A copy of the Programs' Privacy Statement can be found at: www.health.state.ny.us/diseases/aids/resources/adap/index.htm.

If you have questions please call **1-800-542-2437.**

ALL INFORMATION PROVIDED TO THE PROGRAMS IS KEPT STRICTLY CONFIDENTIAL.

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 drivers 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 stubs 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, indicate the gross amount, how often the income is received, and whether it is your income 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.

Rental Income

Income you receive from rental property can be documented by a copy of the lease you have with your tenants and a copy of your most recent income tax return.

All Other Income

Copies of SSD/SSI award letters, unemployment checks, Social Security checks, pension checks, etc. from the past 30 days should be sent as proof of other types of income.

No Income, Supported by Others

If you have no income and are supported by a friend or family member provide a letter from that friend or family member stating how they support you.

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

NEW YORK STATE DEPARTMENT OF HEALTH
Uninsured Care Programs
Empire Station, PO BOX 2052
Albany, NY 12220 1-800-542-2437

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
☐ Self Employed
☐ Unemployment
☐ Worker's Compensation
☐ Public Assistance
☐ SSI (Supplemental Security Income)
☐ SSD (Social Security Disability)
☐ Social Security Retirement
☐ Pension
☐ Veteran's Benefits
☐ Alimony / Child Support
☐ Interest / Dividends / Royalties
☐ Rental Property
☐ No Income, Supported by others
☐ No Income, Living off Savings
☐ Other: _____

For all checked above, please indicate:

Income Source	Gross Amount	How Often	Recipient	Start date
1. _____	$_____	☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Annually	☐ Applicant ☐ Spouse ☐ Household Member	___/___/___
2. _____	$_____	☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Annually	☐ Applicant ☐ Spouse ☐ Household Member	___/___/___
3. _____	$_____	☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Annually	☐ Applicant ☐ Spouse ☐ Household Member	___/___/___

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:

Asset Source	Balance/Value	Recipient
1. _____	$ _____	☐ Applicant ☐ Household Member ☐ Joint
2. _____	$ _____	☐ Applicant ☐ Household Member ☐ Joint
3. _____	$ _____	☐ 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: _____ Group Number: _____

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):

Name	Organization	Relationship	Phone Number
_____	_____	_____	(____) ____–____
_____	_____	_____	(____) ____–____
_____	_____	_____	(____) ____–____

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