

Application

to Receive Allowable Services for HIV/AIDS Patient Care Programs:



Part 1 Applicant Information

- AIDS Drug Assistance Program (ADAP)
- ADAP Program for Medication Co-Payment and Medication Deductibles Premium Plus (Insurance Services)
- State Housing Opportunities for Persons with AIDS (HOPWA)
- Ryan White Part B Consortia and other HIV/AIDS Programs

HIV positive diagnosis is an eligibility requirement.

Check if you are HIV Positive: Yes No Unknown (Provide a copy of an HIV Laboratory Test which shows your HIV status.)

Name

First _____ M.I. _____ Last _____

Date of Birth / / Male Female Transgender SSN - -

M M

D D

Year

Race _____ Ethnicity _____ Language Spoken _____

Are you a Veteran? Yes No Are you receiving Veteran's benefits? Yes No

Are you pregnant? Yes No Don't Know

Do you have a housing need? Yes No

Do you rent? Yes No Monthly Payment \$_____

Do you own your own house? Yes No Monthly Payment \$_____

When were you first diagnosed with HIV? _____

Part 2 Living Arrangements

Address where you currently live:

Street Address _____

City _____ State _____ ZIP Zip _____ County _____

Mailing address: (if different)

Street Address _____

City _____ State _____ ZIP Zip _____ County _____

Telephone:

() - () - () -

Home

Work

Other Contact

Email: _____

How many adults live with you? _____ How many children live with you? _____ (under 18 years of age)

Check how you prefer staff to contact you:

Home Phone Work Phone Other Contact Phone Mail Other _____

Part 3

Medicaid Insurance and Other Programs

Do you have an existing health insurance policy? Yes No

If Yes, provide name of insurance company _____

If No, does your employer offer health insurance as a benefit? Yes No

If No, provide proof from employer showing insurance is not available.

Are you taking a prescription drug(s)? Yes No

If Yes, please list: _____

SCREENING FOR OTHER PROGRAMS

Please check if you are participating in one of the following programs and bring the award or eligibility letter and card as proof:

Medicaid Medicare Project AIDS Care (PAC) SNAP
 Temporary Assistance for Needy Families (TANF) Women, Infants and Children (WIC)
 Name Other: _____

If you have a case manager, please provide his or her name: _____

Household Income means gross income from all sources received by the applicant and the applicant's spouse (if married).

Household Monthly Income Before Taxes and Deductions

(Gross Income)

Part 4 Household Monthly Income

Name (First & Last)	Relationship of person to you	Monthly Work Income	Monthly Social Security	Monthly SSI Retirement Income	Unemployment, Child Support, Public Assistance, Other	Monthly Totals	Check if No Income*
	Applicant	\$	\$	\$	\$	\$	<input type="checkbox"/>
		\$	\$	\$	\$	\$	<input type="checkbox"/>
		\$	\$	\$	\$	\$	<input type="checkbox"/>
		\$	\$	\$	\$	\$	<input type="checkbox"/>
		\$	\$	\$	\$	\$	<input type="checkbox"/>

*If you checked "no income" provide a statement as to how food, clothing and shelter are being provided to you.

Total Monthly Household Income _____

Do you have a checking account? Yes No If yes, what is your current balance? _____

Do you have a savings account? Yes No If yes, what is your current balance? _____

Name of employer(s): _____

Are you self employed? Yes No If yes, what type of business? _____

Business Street Address _____

City _____ State _____ ZIP Zip _____ County _____

Part 5 Rights & Responsibilities (initial each item shown)

_____ I understand that I am responsible for giving truthful and correct information on this application to the best of my knowledge. Failure to be truthful may prevent or delay a determination of eligibility to receive services.

_____ I understand if I knowingly give information that is not true or withhold information and receive services that I am not eligible to receive, I may be lawfully punished and have to reimburse the Department of Health for services.

_____ I understand the information I provide may be verified, which may include computer matching and the information I give about my income may be checked.

_____ I understand that the information will be kept confidential in accordance with Florida and Federal law.

_____ I understand not all services I am eligible to receive may be available, accessible or funded, and I may not meet specific program qualifications for some programs.

_____ I understand that at any time during the application process, I can be denied eligibility if my actions are uncooperative, disruptive of office procedures, threatening or hostile toward staff.

_____ I understand that the Department of Health eligibility staff cannot discriminate because of race, color, sex, age, disability, religion, nationality or political beliefs.

_____ I understand I have the right to ask for a fair hearing if I think the decision of my case was unfair or incorrect.

Applicant Client

Signature

Applicant Client Signature _____ Date _____

For Eligibility Staff Only (optional)

Walk-in Mail Other _____

Date of appointment _____ Eligibility Staff: _____

Date determined eligible: _____ Date referred to: Case Management _____ ADAP _____

AICP _____ HOPWA _____ Other: _____

Date determined ineligible: _____ Date supervisory review: _____

Hearing Fair hearing information was provided: Yes No