

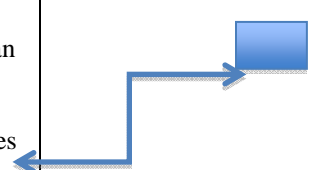


2012 Bridging The Gap, Colorado Application

The information on this form will be used in determining eligibility for the Colorado State Pharmaceutical Assistance Program, Bridging the Gap, Colorado. This form must be signed by the applicant (or the applicant's representative). CDPHE and its contracted agents will maintain all information requested on this form as confidential. Please see the back of this page for information regarding your participation in Bridging the Gap, Colorado

Section 1 – Applicant Information			
Last Name:	First Name:	MI:	
Do you wish to participate in Bridging the Gap in 2012? ___ Yes ___ No	Birth date: ____/____/____	Medicare ID Number: (include letter after social security #) ____-____-____-____ Part A Effective Date: ____/____/____	In the past year, have you submitted an ADAP application and been found eligible? ___ Yes ___ No * ADAP eligibility must be determined before BTGC application can be approved

Section 2 – Bridging the Gap, Colorado (BTGC) is only collecting Medicare Part D Prescription Drug Plan or Medicare Advantage Plan information if you need assistance with premium payments. – If you have a plan with no premium due, or pay the premium yourself, you do not need to provide this information.	
Name of Medicare Plan:	Copy of insurance card attached (Not required)? ___ Yes ___ No
Member ID #	Rx Group:
What is the start date of the plan if it is not in effect?	Have you changed plans for 2012? ___ Yes ___ No

Section 3 – Premium Payment Information: If you wish to get premium payment help, please attach an invoice, or include a premium coupon book with your application (with payment information for 2012), or indicate you will send it at a later date.		
Do you need BTGC to help you pay the premium for this policy? Yes ___ No ___ There is no premium ___	Date payment is to start: ____/____/____	Notes or comments:
Monthly premium that Bridging the Gap, Colorado will need to pay for your Prescription Drug Plan in 2012. <i>An invoice for any month prior to January 2012 will not work.</i> \$ _____ (Maximum of \$80.00 a month will be paid by BTGC). You will have to pay any portion of premium that is higher than this yourself. Please note that if premium invoice is not sent to BTGC, the program assumes no liability for loss of Medicare coverage and member may risk loss of medication access for the remainder of the plan year. Members must monitor premium payment accuracy.		Check here if you will have to send invoice or coupon book at a later date than this application 



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Consent to Participate and Consent to Release Personal and Medical Information

Individuals applying for ADAP or BTGC services must meet eligibility standards. Please note that any listed eligibility standards as well as amount of assistance available may be adjusted at any time. All programs at CDPHE are not an entitlement and are based on available funding. To verify eligibility for this program, CDPHE, or its agents may be required to obtain personal information from other agencies or health care providers.

If you agree to take part in the AIDS Drug Assistance Program or Bridging the Gap, Colorado, the enrollment coordinator will collect personal information including your name, date of birth, address, social security number, Medicare Prescription Drug Plan information, and financial eligibility for the program. The information will be considered confidential, but may be released to your BTGC participating pharmacy, essential case manager and enrollment coordination staff, employees of Ramsell Public Health Rx (the BTGC pharmacy benefits manager), and the Centers for Medicare and Medicaid Services and its agents for the sole purpose of administering the program and for paying your Medicare prescription drug benefits.

Any professional or other reports that may be published to comply with reporting requirements to grantors such as the state or federal government will not use your name or any personal identifying information. Other than as described above for the purpose of administration of the ADAP Program, all client information is kept confidential unless disclosure is specifically consented to by the client, or is otherwise allowed by law.

Consent

I, _____, consent to release of personal and medical information as described above to CDPHE, Ramsell Public Health Rx, the Centers for Medicare and Medicaid Services, and other governmental or public agencies as necessary to determine my eligibility for ADAP services and for the coordination of my pharmacy benefits under my chosen Medicare Advantage or Prescription Drug Plan. I understand that pursuant to the Colorado Governmental Immunity Act, C.R.S. § 24-10-101 *et seq.*, the CDPHE is not liable for damages for any injury arising out of my participation in this program.

This consent shall remain in effect for two years from the date of my signature below unless revoked by me in writing. A photocopy of this signed consent shall be considered as valid and may be relied upon by the agencies participating in this program.

Client Signature: _____

Client Name: _____ **Date:** _____

Witness Name: _____ **(if not signed by applicant)**

Witness Title: _____

Witness Signature: _____ **Date:** _____

Return this application to:
CDPHE HIV Care and Treatment Program
BTGC A3 -3800
4300 Cherry Creek Dr. South, Denver, CO 80246
Telephone: (303) 692-2716 Fax: (303) 782-5393