

Colorado AIDS Drug Assistance Program Eligibility Form

Colorado Department of Public Health and Environment

Check One: New Applicant Renewing Applicant

Check the program (s) for which you are applying:

ADAP Bridging the Gap (SPAP) Insurance Continuation

Instructions: Please fill in all blanks on all six pages. Submit documentation where requested.

Section 1: APPLICANT INFORMATION

| | |
|------|--|
| Date | |
|------|--|

| Name | | |
|------|-------|----|
| Last | First | MI |

| | | |
|------------------------|------------|---|
| Social Security Number | Birth date | Language <input type="checkbox"/> English <input type="checkbox"/> Spanish |
|------------------------|------------|---|

| Gender | | |
|-------------------------------|---------------------------------|---|
| <input type="checkbox"/> Male | <input type="checkbox"/> Female | Transgender <input type="checkbox"/> Male to Female <input type="checkbox"/> Female to Male |

| Ethnicity | | | |
|-----------------------------------|---------------------------------------|----------------------------------|---|
| <input type="checkbox"/> Hispanic | <input type="checkbox"/> Non-Hispanic | <input type="checkbox"/> Unknown | <input type="checkbox"/> Prefer not to answer |

| Race | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> White | <input type="checkbox"/> Black or African American | <input type="checkbox"/> Asian |
| <input type="checkbox"/> Native Hawaiian/Other Pacific Islander | <input type="checkbox"/> American Indian/Alaska Native | <input type="checkbox"/> Multi-racial |
| <input type="checkbox"/> Unknown | <input type="checkbox"/> Prefer not to answer | |

| Phone and Email: Please describe any concerns you may have with staff contacting or leaving messages at the below numbers and addresses. | | | |
|--|------|----------------------------|---------------|
| Home | Cell | Work (including extension) | Email Address |
| List concerns / limitations | | | |

| Residential Address (where you live) | | | |
|--|------|-------|-----|
| Street | City | State | Zip |
| May we contact you at this address? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |

| | | | |
|--|------|-------|-----|
| Mailing Address (Check here if same as residential address <input type="checkbox"/>) | | | |
| Street | City | State | Zip |
| May we contact you at this address? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |

| | | | |
|---|-----------------------------------|---|-----|
| Emergency Contact (Friend or relative) | | Aware of Status? Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| Name | Phone Number and/or Email Address | | |
| Street | City | State | Zip |

| | |
|--|--------|
| Who helped you complete this application? (Check here if you don't have anyone to assist you <input type="checkbox"/>) | |
| Name | Agency |

| | | |
|--|--|--|
| Proof of Colorado Residency (Check here if documentation is attached <input type="checkbox"/>) | | |
| <input type="checkbox"/> Current, unexpired Colorado drivers license or identification card | <input type="checkbox"/> Government-issued identification card | <input type="checkbox"/> Lease with Colorado address |
| <input type="checkbox"/> Utility bill with Colorado service address (gas, electric or water) | <input type="checkbox"/> Signed letter from case manager / social worker (homeless or transitional housing) | <input type="checkbox"/> Mortgage statement with Colorado address |
| <input type="checkbox"/> Rent Receipts (Colorado address must be printed on the receipt) | <input type="checkbox"/> Hotel Receipts (Colorado address must be printed on the receipt) | <input type="checkbox"/> Other (describe): |

| | |
|--|---|
| Pregnancy (if female) | |
| Are you currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know | If you are pregnant, what is your estimated delivery date? |

| | | |
|---|---|--|
| Marital Status | | |
| <input type="checkbox"/> Single | <input type="checkbox"/> Married | <input type="checkbox"/> Divorced |
| <input type="checkbox"/> Widowed | <input type="checkbox"/> Other _____ | |

Section 2: EMPLOYMENT INFORMATION

| | | | | |
|---|---|---|--|---|
| Employment Status | | | | |
| <input type="checkbox"/> Full time _____ hours per week | <input type="checkbox"/> Part Time _____ hours per week | <input type="checkbox"/> Seasonal/ temporary | <input type="checkbox"/> Unemployed | <input type="checkbox"/> Self employed |
| Name of employer(s), if employed: | | | | |
| Employer Size: <input type="checkbox"/> Less than 50 employees <input type="checkbox"/> 50 employees or more <input type="checkbox"/> Not applicable | | | | |

Section 3: HEALTH STATUS

| Health Status: | | | |
|---|--|--|------|
| When were you diagnosed as HIV positive? _____ / _____ Month year | | Who administered the HIV test? Agency/physician name _____ City, State _____ <input type="checkbox"/> Do not remember | |
| Have you ever been diagnosed with AIDS? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Most recent CD4 Count # | Date | Most recent Viral Load # | Date |
| Have you been tested for Hepatitis C? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Prefer not to answer | | If you have been tested for Hepatitis C, what were the results? <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate <input type="checkbox"/> Prefer not to answer | |
| Who prescribes (or will prescribe) your HIV medications? | | _____ _____ Agency or Doctor Name Telephone number | |
| If you were found to be eligible for ADAP, where would you get your medications? | | | |
| <input type="checkbox"/> Denver Health | <input type="checkbox"/> Walgreens at Children's Hospital | <input type="checkbox"/> Walgreens at Rose Medical Center | |
| <input type="checkbox"/> University of Colorado Hospital | <input type="checkbox"/> Other (Please Specify) _____ | <input type="checkbox"/> I do not know, I need help picking a location | |
| <input type="checkbox"/> I would pick up my medications from one of the above pharmacies | | | |
| <input type="checkbox"/> I need to receive a mail order of my medications | | | |

Section 4: HEALTH INSURANCE INFORMATION

Please tell us if you are enrolled in any of the following programs. You may be required to provide proof of denial if it appears you may be eligible. If you have medical coverage, please attach a copy of your health insurance card and prescription drug card.

| Colorado Medicaid (check only one box) | | | |
|---|--|---|---|
| <input type="checkbox"/> Applied, decision pending Date of application: ____/____/____ | <input type="checkbox"/> Applied, not eligible (Attach copy of letter) | <input type="checkbox"/> Applied, eligible (Attach copy of letter and card) | <input type="checkbox"/> Never applied Explain why you have never applied for Medicaid: |

| Medicare (check all that apply. Attach copies of Medicare card and policies) | | | | |
|--|---|--|---|--|
| <input type="checkbox"/> I have no Medicare coverage | <input type="checkbox"/> Covered under Part A (inpatient) | <input type="checkbox"/> Covered under Part B (outpatient) | <input type="checkbox"/> Covered under Part D (prescription plan) | <input type="checkbox"/> I'm eligible for Medicare but use private insurance instead |

| Other Governmental Health Insurance Programs (check all that apply) | |
|--|---|
| <input type="checkbox"/> Covered under State Children's Health Insurance Program (S-CHIP) (Attach copy of S-CHIP card) | <input type="checkbox"/> Covered under other governmental health insurance (VA, Indian Health) (describe below) |

| Private Health Insurance (check all that apply) | | |
|--|---|--|
| <input type="checkbox"/> I am covered under a plan through my employer | <input type="checkbox"/> I am covered under a plan through a retirement plan | <input type="checkbox"/> I have an individual health insurance policy |
| <input type="checkbox"/> I am covered under COBRA which expires on ____/____/____ MM DD YYYY | <input type="checkbox"/> I am covered under someone else's policy | <input type="checkbox"/> I am eligible for health insurance under someone else's policy |
| <input type="checkbox"/> My employer offers health insurance, but I do not participate | <input type="checkbox"/> I am not eligible for or covered by private health insurance | <input type="checkbox"/> I am unsure if I am eligible for or covered by private health insurance |
| If you are eligible for private health insurance, but not currently covered, explain why: | | |

If you are covered under private health insurance, provide the following information:

Which of your prescribed medication are NOT covered by the plan?

What is the year maximum on your prescription drug benefit? \$_____

What are your monthly prescription drug (out of pocket) co-payments? \$_____

What are your plan's annual deductibles? \$_____

ADAP Certification and Authorization of Release of Information

- I certify that the information provided in this application is complete and accurate, to the best of my knowledge.
- I understand that my failure to be accurate and complete may prevent or delay a determination of eligibility to receive assistance from ADAP.
- I understand that, for the purposes of determining my eligibility for ADAP, the CDPHE, its contractors and subcontractors may request further documentation to verify my HIV positive serostatus, my Colorado residency, and my financial, employment or insurance information as necessary.
- I authorize my prescribing physician, case manager, other departments and programs of the State of Colorado, and other information sources to release information necessary to complete the application process, to verify the accuracy of any information provided in this application, and to verify my ongoing eligibility for ADAP. I further authorize the CDPHE to utilize data from public health records to verify that I am living with HIV.
- I authorize the CDPHE to release information to my physicians, case manager, treatment centers, and other healthcare providers to facilitate provision of ADAP services.
- I understand and agree to submit periodic information regarding my continued eligibility for ADAP, including proof of income, proof of residency, health insurance coverage, and general updates on forms provided by the CDPHE. I understand that changes in my situation will be evaluated to determine my continued eligibility for ADAP. I will be notified in writing if I am to be discontinued from ADAP.
- I agree to notify, or have my case manager notify, the CDPHE of any circumstances affecting my participation in, or eligibility for, ADAP. I agree to notify the CDPHE within thirty (30) days if I change my address or other preferred contact information. I further authorize the CDPHE to contact the persons listed as "Emergency Contact" on this form if the CDPHE's attempts to contact me have been unsuccessful.
- I understand that I am to renew each year in a timely manner at my birth month so as to maintain eligibility.
- I understand that my ADAP eligibility will terminate if:
 - I do not cooperate with efforts to verify information in this application, or
 - I do not comply with the activities needed to identify/verify potential sources of alternative coverage, or
 - I fail to seek insurance coverage, as instructed by the CDPHE, for which I may be eligible, or
 - The CDPHE becomes aware of material misrepresentation, withheld information, or documented fraud, or
 - Qualifying medication is no longer being prescribed to me.
- I understand that the CDPHE reserves the right at any time and without notice to modify the ADAP application form.
- I understand that my assistance through all CDPHE programs is contingent on state and federal funding. This funding is limited and may expire at any time without extended or alternative funds being available.
- I understand that completing this application does not ensure that I will qualify for this program.
- I understand that my name, address and any other personal identifying information provided in this application will be available to the CDPHE and its contractors and subcontractors, and that this information will not be disclosed to anyone else, except as required or permitted by law.
- I understand that I have a right to ask for a full hearing if I feel that a decision on my eligibility was unfair or incorrect or if I believe CDPHE staff or contractors discriminated against me based on my age, race, ethnicity, sex, gender identity, disability, religion, nationality, or sexual orientation.
- 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 ADAP.
- I understand that I may revoke this authorization at any time in writing. However, the release shall remain valid until such time as I inform the ADAP, in writing, of my wish to terminate services through the program, or until such time as I no longer qualify for these services, whichever occurs first, except to the extent that action has been taken in reliance on this authorization.
- A copy of this authorization has the same effect as the original.

Applicant Name (Please Print)

Applicant Signature

Date

**PLEASE REMEMBER TO
NOTIFY ADAP IF
ANYTHING IN THIS
APPLICATION CHANGES**

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

ADAP APPLICATION CHECKLIST

Please enclose the following items that apply to you in the manila self-addressed envelope. **Incomplete applications cannot be processed.**

- Signed ADAP Application**
- Proof of Colorado Residency (which includes one of the following: non-expired copy of a Colorado driver's license or ID card with current address, a utility bill/lease, or letter from your social worker/case manager (on their letterhead) detailing your current resident status**
- Monthly gross income documentation (which includes: copy of one month of consecutive paychecks/stubs or *if* self-employed a copy of last years taxes)**
- A copy of your current SSI/SSDI award letter (must include *gross* amount awarded)**
- A letter stating how you are being supported, if you have no income, from the individual or organization that is supporting you**
- A letter from your employer stating whether or not you are eligible for your employer's insurance and if you are eligible when is your next enrollment period**
- A letter from Social Security stating whether or not you are eligible for the Medicare Part D Prescription Drug Program. If enrolled we need copy of your Medicare Part D card**
- A Copy of last year's tax return, if filed**