Colorado AIDS Drug Assistance Program Application Form –

For Use by First - Time Applicants only

Use this form to apply for the Colorado AIDS Drug Assistance Program (ADAP), which includes HIV Medication Assistance (for the uninsured), Health Insurance Assistance, and Bridging the Gap, Colorado (for Medicare recipients). **Use this form only if you have never been on any Colorado ADAP - sponsored assistance before.** Please complete all of the information requested on this form. If approved, federal legislation requires the Colorado Department of Public Health and Environment (CDPHE) to review client eligibility twice a year.

If you don't know if you've been on ADAP before, call (303) 692-2716.

1. Full Legal Name (Last):	(First):	(Middle Initial):

2. What is your date of birth? _____/_____/_____ (MM/DD/YYYY)

3. What is your Ethnicity? ☐ Hispanic/ Latino(a) ☐ Non-Hispanic ☐ Unknown ☐ Prefer Not To Answer

4. What is your Race? **Check all that apply**

☐ White
☐ Black or African/ African American
☐ Native American/Pacific Islander
☐ American Indian or Alaska Native
☐ Asian
☐ Unknown
☐ Prefer Not to Answer

5. What is your preferred language? ☐ English ☐ Spanish ☐ French ☐ Other _____

6. What is your gender?

☐ Male ☐ Female ☐ Transgender, male to female ☐Transgender, female to male

7. What is your current housing status:

☐Permanent： I rent, own, or share my current residence
☐Temporary: I am in a temporary housing situation (homeless, halfway house, shelter, staying with friends)
☐I am in an institution (hospice, nursing home, etc.)
☐Unknown/ refuse to answer

8. What is your current **residential** address?

Street Address (PO Boxes will **NOT** be accepted)		May we contact you at this address? ☐ Y ☐ N	
City	State	ZIP Code	**County**

You must attach proof that you live at this address.
Please see the instructions for the kind of proof ADAP will accept.

9. What is your current **mailing** address (If different than your residential)?

Street Address (PO Boxes **will** be accepted, but not outside Colorado)		May we contact you at this address? ☐ Y ☐ N	
City	State	ZIP	**County**

10. At what phone numbers can we reach you during daytime hours?

Phone Number ( ) ☐ Home ☐ Work ☐ Cell Phone
May we leave a message on this phone? ☐ Y ☐N

Phone Number ( ) ☐ Home ☐ Work ☐ Cell Phone
May we leave a message on this phone? ☐ Y ☐N

11. Is there anyone that our staff may call if your mail is returned to us (or your phone number does not work)? ☐ Y ☐N
Name: Phone Number: ( )

Does this person know that you are HIV positive? ☐ Y ☐N

12. Do you have a case manager/social worker at an AIDS Service Organization or Medical Clinic? ☐ Y ☐N
If yes, list them below:

Name _____Agency/ Clinic _____

Name_____Agency/ Clinic_____
If you do not currently have one, would you like ADAP to make a referral to a case manager or social worker?
☐ Y ☐N

13. What is your current relationship status?
☐ Single ☐ Married ☐Legally Separated ☐Divorced ☐Widowed ☐Other _____

For ADAP purposes, "married" refers to legally recognized marriages in Colorado.
This information affects your income eligibility for ADAP.

14. How many children do you have living with you? _____ How many **other** children do you have *that don't live with you* but you provide 50% or more of their monthly support _____

15. If you are **female**, are you pregnant? ☐ Y ☐N ☐ Not Applicable
If yes, when are you due to deliver?_____(Month)

16. What is your Social Security Number (if you have one)? _____-_____-_____

MEDICAL INFORMATION

17. When you were first diagnosed as HIV positive? Month_____ Year _____ (estimate if necessary)

Where were you diagnosed? City_____ State:_____

18. Have you **ever** been told by your doctor or a laboratory that you have AIDS? ☐ Y ☐N ☐ Not Sure

19. Have you ever been told that you have Hepatitis C? ☐ Y ☐N ☐ Not Sure

20. Which of the following applies to your situation? (check all that apply)
- ☐ I am currently taking medications, and I need help paying for them through Colorado ADAP
- ☐ I was recently told I need to begin medications
- ☐ I **had** been on medications, but I stopped for awhile
- ☐ I have not been prescribed medications yet, but I want to be prepared
- ☐ Other medication issue: (I lost insurance, Medicaid, etc.).

21. Have you been on HIV medication assistance (ADAP) in any state **other** than Colorado? ☐ Y ☐N

Have you been on a waitlist for ADAP in another state? ☐ Y ☐N

22. If you answered "yes" to question 21,

In which state (most recently)? _____ How long ago? Month_____ Year____ ☐ I don't know

23. Where would you like to pick up your medications? ☐ Denver Health ☐University Hospital
☐ Pick up or mail order through Walgreens at Rose Medical Center ☐ I need help deciding
☐ A different pharmacy **(*for members with insurance or Medicare only):*** ☐ King Soopers/City Market
☐ Walgreens ☐ Other:_____ City:_____

24. Do you currently have a doctor **in Colorado** that writes your **HIV** medication prescriptions?
☐ Y ☐N
If yes, what is that doctor's name?

25. If you answered "no" to question 24, would you like a referral for HIV medical care? ☐ Y ☐N

26. In the past twelve months, have you had labs drawn to check your CD4 count and / or viral load?
☐ Y ☐N ☐ Not Sure

27. If you answered "no" to question 26, please explain why (couldn't afford, didn't think it was necessary):

Your CD4 counts and viral load results are reported directly to CDPHE by your laboratory. Federal legislation requires that these laboratory results be reported to the US Health Resources and Services Administration (HRSA). However, these numbers will NOT be linked to your name in this report to HRSA. We will submit this information to HRSA using a unique and anonymous ID number only. ***If you are new to Colorado, or if an in-state lab has not reported your CD4 and Viral Load to CDPHE, we will contact you to request written laboratory reports of these numbers.***

HOUSEHOLD INCOME, ACCESS TO HEALTH INSURANCE, AND OTHER PUBLIC ASSISTANCE

28. Have you applied for Medicaid ***(including SSI)*** in Colorado? (Check any that apply)
☐ I don't know
☐ No, I've never applied
☐ Yes, but not in the last year
☐ Yes, I recently applied on _____/_____(mm/yyyy)
If you recently applied, what is the status of that application? ☐ Approved ☐ Denied
☐ I am still awaiting a decision about my Medicaid eligibility
☐ I'm on a Medicaid waitlist

If you applied for Medicaid **and were denied**, what reason did they give you?
☐ They said I made too much money ☐ They said I was still able to work ☐ I can't remember
☐ Other Reason:

29. Are you eligible for Medicare? ☐ Y ☐ N

If yes, which Parts are you enrolled in?
☐PART A Effective Date ____/_____☐PART B Effective Date ____/____ ☐PART D Effective date ____/____

If you are, or become, Medicare-eligible, you must submit an additional "Bridging The Gap, Colorado" application. Call the ADAP Helpdesk at 303-692-2716 to ask about this application.

30. Are you enrolled/ enrolling in Cover Colorado High Risk Insurance Plan? ☐ Y ☐ N
Are you enrolled/ enrolling in GettingUSCovered Colorado Pre-existing Insurance Plan? ☐ Y ☐ N

31. Which of the following best describes your employment status?

☐ Unemployed for more than 6 months
☐ Retired/Disabled
☐ Self-employed
☐ Recently unemployed as of _____/_____/_____
☐ Applying for disability
☐ Other: _____

☐ Employed by _____ and working _____ hours per week

32. If you are employed, when did you start this job? ____ /_____ (mm/yyyy) ☐I am not employed

33. Are you eligible for health insurance yourself, or though your employer, spouse, or some other individual?

☐ Y ☐ N ☐I do not know

If yes, when did you become eligible? ____ /_____ (mm/yyyy)

34. **If** you are eligible for health insurance (through your employer, spouse, or other individual) are you enrolled in it? ***(This also includes COBRA or Individual Private Insurance Plans).***

☐ N/A - I am not eligible for health insurance
☐ Yes, I am enrolled
☐ No, because it does not cover the services I need
☐ No, because I'm afraid my employer would find out I'm HIV positive
☐ No, because it's too expensive
☐ No, because of a pre-existing condition limitation
☐ No, for another reason (explain) _____
_____
_____

If you or your spouse are employed, and you are NOT already receiving assistance from ADAP for the costs of health insurance, you will need to have your employer complete the "Employer Insurance Information Form" on page 6 and attach it to your application form. A copy of this form must be filled out *for each family member who is currently employed.*

If you answered that you were worried your employer would find out about your HIV status, you will be contacted by ADAP staff to discuss an alternative.

~ Please continue to the next page ~

32. Please use the tables below to describe the total monthly income for your household. Please **provide your gross income (before deductions) rather than your net income.** You will need to attach proof of all income listed in this table, whether earned by you or another member of your household. See the instructions for the types of proof that ADAP will accept.

Only include household members who contribute income to your household. Include income from your legally married spouse (question 13) and income earned by your children (question 14). Do NOT include other people living in your household unless you are **under 18**, in which case you need to list your parent or legal guardian's income. Attach additional sheets if you have more than 4 people receiving income in your household.

Did you or your spouse work this month or expect to work next month? ☐ Y ☐ N

Include temporary and seasonal work and income from self-employment. ***If you have no household income ($0) from employment or from any other source, fill out "Statement of Support" on page 8.***

Name of Worker ***(you, spouse ,dependent, etc.)***	**Employer Name**	**Start date** ***(or continuing)***	**Is this work temporary or seasonal?**	**Monthly Amount (average)**
			☐ Y ☐ N	**$**
			☐ Y ☐ N	**$**
			☐ Y ☐ N	**$**
			☐ Y ☐ N	**$**

Did you, your spouse, or any dependent receive income from any of these other sources? ☐ Y ☐ N

If yes, check all that apply and fill out this table:

□ Unemployment benefits
□ Short/Long-term disability
□ SSI (Supplemental Security Income)
□ Worker's compensation
□ SSDI (Supplemental Security Disability Insurance)
□ AND (Aid to the Needy Disabled)
□ TANF (Temporary Aid to Needy Families)
□ Interest/Investment Income
□ Veterans benefits
□ Retirement/Pension
□ Taxable trust income
□ Alimony paid to you
□ Other (please describe): _____

THIS CHECK COMES TO: ***(me, my spouse, my child, etc.)***	**Type of Benefit or Income from list above** ***(for example, "SSI")***	**Monthly Amount (Gross Amount)**
		$
		$
		$
		$

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 recertify for ADAP twice per year in a timely manner at my birth month and six months after my birth month.
- 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 other forms of 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 of 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.

PLEASE REMEMBER TO NOTIFY ADAP IF ANYTHING IN THIS APPLICATION CHANGES

_____ _____ _____

Applicant Name (Please Print) Signature of Applicant or Parent/Guardian Date

Return this application to: CDPHE Care and Treatment Program
ADAP-3800, 4300 Cherry Creek Drive South, Denver, CO 80246
Fax: 303-691-7736 Phone: 303-692-2716

Employer Insurance Information Form

APPLICANT: This form is required if you or your spouse are employed and you have said that you are not eligible for or enrolled in health insurance. This may be because your employer does not offer health insurance, you are not eligible for specific reasons, or the insurance does not cover needed services. ***A copy of this form must be provided for every family member that is currently employed.***

EMPLOYER: Please complete this form, have an authorized representative sign it, and return the form to the employee. This information will need to be provided every six months.

EMPLOYEE NAME:
EMPLOYER (Business Name)

To be completed by the EMPLOYER:

1. Do you offer a health insurance plan to any of your employees? □ Yes □ No
   *If **NO**, skip to the signature portion of this form*
   *If **YES**, to whom was the health insurance offered, and was it accepted?*

Employee	□ Not eligible □ Offered, but not accepted □ Offered and accepted	If not eligible, explain if this person could become eligible in the future, and when (e.g., becomes full time). Potential eligibility date: ___/____/_____
Spouse Name(s): _____	□ Not eligible □ Offered, but not accepted □ Offered and accepted	If not eligible, explain if this person could become eligible in the future, and when (e.g., employee becomes full time). Potential eligibility date: ___/____/_____
Dependent(s) Name(s): _____ _____	□ Not eligible □ Offered, but not accepted □ Offered and accepted	If not eligible, explain if dependents could become eligible in the future, and when (e.g., employee becomes full time). Potential eligibility date: ___/____/_____

2. What is the date for your company's next open enrollment period? ____/_____/_____
   When does coverage begin after open enrollment? _____/_____/_____

COMMENTS: _____

➲ **Please attach a copy of your employee benefits summary or other plan information, if available.**

EMPLOYER REPRESENTATIVE COMPLETING THIS FORM:	**TITLE:**	**PHONE:**
EMPLOYER'S AUTHORIZED SIGNATURE		**DATE:**

EMPLOYER: Please return this form to the employee along with explanation of benefits

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STATEMENT OF SUPPORT FOR _____ (NAME OF APPLICANT)

COMPLETE THIS FORM ONLY IF YOU CANNOT PROVIDE PROOF OF RESIDENCY IN YOUR NAME

OR IF YOU REPORT $0 HOUSEHOLD INCOME

SECTION 1 – IF **SOMEONE ELSE** PROVIDES YOU WITH SUPPORT, HAVE HIM/HER FILL OUT THIS PART OF THE FORM AND HAVE HIM/HER SIGN IN SECTION 3. **THIS PERSON MUST PROVIDE PROOF THAT THEY RESIDE AT THE ADDRESS LISTED.**

Name of person providing support:

_____

What is your relationship to the applicant?

- ☐ Legally married in the State of Colorado
- ☐ Domestic partner/civil union/partner
- ☐ His/her parent (biological or adoptive)
- ☐ His/her child (biological or adoptive)
- ☐ Other relative (brother, sister, aunt, uncle, brother-in-law, mother-in-law, etc.)
- ☐ Other (friend, neighbor, etc.)

Type of support provided for free or minor charge (check all that apply):

- ☐ Lodging
- ☐ Food
- ☐ Telephone
- ☐ Other (describe): _____

For what part of the past 12 months did the applicant live in your household? _____

On your most recent U.S. Tax Return, did you claim the applicant as a dependent?

- ☐ Yes
- ☐ No
- ☐ Have not filed a U.S. Tax Return

Please provide current contact information so we can contact you to verify any information.

Mailing Address: _____

_____

Daytime Phone (____) ____ - _____

SECTION 2 – IF YOU HAVE $0 OF HOUSEHOLD INCOME AND ARE **NOT RECEIVING SUPPORT FROM ANY OTHER INDIVIDUAL**, COMPLETE THIS PART OF THE FORM AND SIGN IN SECTION 3.

Explain how you cover the costs of the following:

Housing/shelter _____

_____

Food _____

_____

Transportation _____

_____

Telephone _____

_____

Utilities _____

Other
(Cigarettes, etc.) _____

If you are living off of savings, please provide a bank statement or describe why such documentation is not available (for example, your savings is in the form of cash or a reloadable credit card):

_____

_____

_____

V07312012

SECTION 3 – LEGALLY BINDING SIGNATURE

By signing below, I assert that the contents of this form are complete and accurate, to the best of my knowledge. ***I acknowledge that intentional misrepresentations in this form may constitute an attempt to defraud the State of Colorado, which could result in severe criminal and civil penalties****. I authorize the State of Colorado to contact me and to conduct other research necessary to verify the accuracy of the statements made on this form.*

_____ _____ _____

Support Provider Signature | Applicant Signature | Date