Colorado Department of Public Health and Environment

2013 Bridging the Gap Colorado **Application**

SECTION 1: APPLICANT INFORMATION

INCOMPLETE SUBMISSIONS WILL NOT BE ACCEPTED

In order to renew your eligibility for Bridging the Gap Colorado, this form must be filled out completely. Fill out all information you know and mail or fax it to Colorado ADAP using the information at the end of this packet. If you are requesting a new Medicare card, please fill out your name and put your Social Security number in place of your Medicare claim number. Also, please indicate what parts of Medicare you know you receive.

Your current Zip Code:	If this is your first time applying for Bridging the Gap Colorado, please check here: ☐

MEDICARE HEALTH INSURANCE

NAME OF BENEFICIARY (your name)	
MEDICARE CLAIM NUMBER	SEX
IS ENTITLED TO: (PLEASE CHECK ALL THAT APPLY) **HOSPITAL (PART A)** ☐ **MEDICAL (PART B)** ☐	EFFECTIVE DATES _____ _____

IF YOUR MEDICARE CARD HAS BEEN LOST OR STOLEN, PLEASE CHECK HERE: ☐

You must complete **SECTION 2** on the following page and submit it with your application.

ADAP will request a replacement card be sent to you on your behalf ONCE, AND ONLY ONCE.

LOW-INCOME SUBSIDY INFORMATION:
(If you make more than $1,396 a month, please skip to PLAN PREMIUM INFORMATION)

Are you currently receiving "Extra Help" from Medicare for your Part D costs? (Check One):

Yes ☐ / No ☐ / I Don't Know ☐

If No or Don't Know, please complete the following information. This information will not be used to determine eligibility for ADAP's programs but instead will be used as a guide to determine if you may qualify for any financial assistance programs provided by Social Security or Medicaid. ADAP reserves the right to complete an application for Low-Income Subsidy on your behalf. You may receive information about Medicare Savings Programs in the mail.

SOCIAL SECURITY INCOME:	Do you own any property ***in addition*** to the home that you live in and/or any vehicles you may own? (do not count your house you live in, vehicles or burial plots)
OTHER INCOME:	

PLAN PREMIUM INFORMATION

IF YOUR PLAN FOR 2013 HAS A PREMIUM AND YOU WOULD LIKE BRIDGING THE GAP TO HELP PAY IT, PLEASE CHECK HERE ☐ See **SECTION 3** of this packet.

By signing below, I attest that the above information is, to the best of my knowledge, true and accurate. In addition to the consent granted to ADAP by the release of information included in the ADAP recertification, I grant Bridging the Gap Colorado my permission to correspond with the Centers for Medicare and Medicaid Services (CMS) and my Part D Plan in order to obtain information that they may need in order to coordinate pharmaceutical benefits through Medicare. I grant Bridging the Gap Colorado permission to enroll me in "Extra Help" for Part D if it is determined that I qualify.

Name: _____ Signature:_____ Date:_____

SECTION 2: NEW MEDICARE CARD REQUEST

If you have your Medicare ID, DO NOT complete this section

The purpose of this form is to request a new copy of your Medicare ID card from Social Security. If you have your Medicare card, you do not need to complete this section. If you are requesting a new Medicare ID card, please complete the information below and mail or fax it to the Colorado ADAP using the information on the following page. Below is a sample of what your Medicare card looks like, in case you may have it.

Once this form is received and submitted to the Social Security Administration, it may take up to 30 days to receive your new card. Once it is received, sign the card and make 2 copies of it. Send one copy to the Colorado ADAP by faxing it or mailing it using the information on the following page. Take the other copy, black out the first 5 numbers in your claim number using a Sharpie and carry that copy with you to prevent your information falling into the wrong hands. Place the original in a safe place where you will remember its location. ADAP will only make ***one*** request for a new card on your behalf.

SOCIAL SECURITY NUMBER	FIRST NAME	M.I.	LAST NAME	SUFFIX

LAST NAME AS IT APPEARS ON YOUR MOST RECENT MAILING FROM THE SOCIAL SECURITY ADMINISTRATION	DATE OF BIRTH	HAVE YOU HAD A RECENT CHANGE OF ADDRESS THAT HAS NOT BEEN REPORTED TO SOCIAL SECURITY? YES ☐ NO ☐

CURRENT ADDRESS LINE 1	CURRENT ADDRESS LINE 2

CITY	STATE	ZIP CODE	DAYTIME PHONE

I hereby grant the Colorado AIDS Drug Assistance Program (ADAP) permission to submit the above information to the Social Security Administration on my behalf with the intent of requesting a replacement Medicare ID card. I understand that neither any information regarding my involvement in the ADAP nor my HIV status will be disclosed to the Social Security Administration for this purpose. It is my responsibility to ensure the Colorado ADAP receives a copy of this card to store for their records.

Name:_____ Signature:_____ Date:_____

SECTION 3: PREMIUM PAYMENT INFORMATION

If you do not have a plan premium or are paying the premium yourself, DO NOT complete this section

If you have a premium payment you would like BTGC to pay, **but don't have a copy of your 2013 invoice or payment coupon book available yet,** please put this page in a place you will remember it (for example, on your refrigerator) for when you receive your 2013 Part D coupon book or premium invoice. If you have already received your invoice or coupon book, please read the agreement below, sign and return this form with the applicable invoice/coupon to the Colorado ADAP using the information below. BTGC will pay up to $80.00/month for your Part D plan premium.

If you received a coupon book, please affix ***ONE COUPON*** in the space provided below using tape and keep the remaining coupon book for your records. If you have an invoice, please make sure your name is visible on the invoice and staple it to this page.

AFFIX COUPON HERE

Any portion of the premium that applies to dental, vision or hearing coverage, or exceeds the $80.00 limit will be your responsibility to pay. BTGC will not be held liable for any loss of coverage that results from non-payment on your behalf or for any plan for which a premium invoice was not submitted to the Colorado ADAP for payment. It is your responsibility to notify the Colorado ADAP of any correspondence you may receive from your Part D plan regarding changes to coverage, late payments or possible discontinuation. You are also required to surrender any refund checks given to you by your Part D plan for any services paid by the Colorado ADAP for premiums or co-pays as that money is the sole property of the Colorado ADAP. Failure to surrender checks in a timely manner will result in discontinuation of coverage until the funds have been returned to the Colorado ADAP. By signing below, you agree to these terms and conditions. Please provide your phone number in case we need to reach you for questions.

Name:_____ Signature:_____ Phone Number_____

No premium shall be paid on your behalf until this signed document is received with a premium invoice or Part D coupon. Mail or fax this completed form with a copy of your premium invoice or coupon book to the information below.

Colorado Department of Public Health and Environment

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RYAN WHITE CARE ACT