Application

to Receive Allowable Services for HIV/AIDS Patient Care Programs

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

Florida HEALTH

Part 1 Applicant Information

HIV positive diagnosis is an eligibility requirement.
Check if you are HIV Positive: ☐ Yes ☐ No ☐ Unknown (Provide a copy of an HIV Laboratory Test that shows your HIV status.)

Name:
First M.I. Last

Date of Birth: M M / D D / Y Y Y Y ☐ Male ☐ Female ☐ Transgender

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 County

Mailing address (if different):
Street Address
City State 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. Proof provided? ☐ Yes ☐ No

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 letter, eligibility letter, or card as proof:

☐ Medicaid ☐ Medicare ☐ Project AIDS Care (PAC) ☐ Supplemental Nutrition Assistance Program (SNAP)

☐ Temporary Assistance for Needy Families (TANF) ☐ Women, Infants, and Children (WIC)

☐ Other:_____

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

SKIP PART 4 IF YOU HAVE PROOF OF ELIGIBILITY FOR ONE OF THE ABOVE PROGRAMS.

Part 4 Household Monthly Income

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)

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	$	$	$	$	$	☐
		$	$	$	$	$	☐
		$	$	$	$	$	☐
		$	$	$	$	$	☐
		$	$	$	$	$	☐

*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 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 that 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 eligiblity 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.

Client Signature

_____ _____

Client Signature Date

For Eligibility Staff Only (optional)

☐ Walk-in ☐ Mail ☐ Other:_____Date determined eligible:_____

Date of appointment:_____ Eligibility staff:_____

Date referred to: Case Management_____ADAP_____ADAP Premium Plus_____HOPWA_____Other_____

Date determined ineligible:_____ Date supervisory review:_____

Fair hearing information was provided? ☐Yes ☐ No

Florida HEALTH