# 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

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## 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



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