State of California
Health and Human Services Agency

California Department of Public Health

AIDS Drug Assistance Program Enrollment Application

Phone: 1 (844) 421-7050 ADAP Fax: 1 (844) 421-8008

Required fields will be denoted with an asterisk (*)
Required fields, if applicable will be denoted by two asterisks (**)

Client ID________________

Type of application*: Initial Update Re-enroll Re-Cert/ SVF with Changes

Section 1 Profile

First Name*________________________Middle Initial_____Last Name*________________________

Date of Birth*_______________________Social Security Number______________________________

Residential Address_________________________________Apartment Number_________________

City______________________________State______Zip___________County____________________

Homeless

May we send mail to this residential address?*

Yes No, use mailing address No, use enrollment site

Mailing address*____________________________________Apartment Number_________________

City*____________________________State*______Zip*__________County____________________

Phone Number_______________________ Email address___________________________

Section 2 Demographics

What is your sex at birth?* Male Female Unknown

Are you pregnant?* Yes No

What is your gender?*

Male Female Transgender, Male to Female

Transgender, Female to Male Transgender, Unknown Unknown

What is your ethnicity?* Hispanic **(see E1)** Non-Hispanic

E1.If Hispanic, how would you identify?** (Check all that apply)

Mexican, Mexican American, Chicano/Chicana Puerto Rican Cuban

Spanish, Portuguese, Cape Verdean Other Hispanic Not Applicable

What is your race? (Check all that apply)**

White Black or African American Asian **(See R1)**

Native Hawaiian/ Pacific Islander **(See R2)** American Indian Decline to Provide

R1. If Asian, how would you identify (Check all that apply)*

Asian Indian	Bangladeshi	Burmese	Cambodian	Chinese
Filipino	Hmong	Indonesian	Japanese	Korean
Malaysian	Pakistani	Singaporean	Sri Lankan	Taiwanese
Vietnamese	Laotian	Thai	Other Asian	

R2. If Native Hawaiian/ Pacific Islander, how would you identify (Check all that apply)**

Fijian Guamanian or Chamorro Native Hawaiian

Samoan Tongan Other Pacific Islander

Section 3 Clinical

What is your HIV status?* HIV Positive, not AIDS CDC-defined AIDS

Viral Load____________________Date of Viral Load ______________________

CD4 Count __________________Date of CD4 Count ______________________

Section 4 Household

What is your current status?* Single Married Legally Separated

Divorce In a Domestic Partnership

Household size (Persons including yourself*______

Annual Household Income*____________________

Year for Household Income (Current or previous year)*________________

Section 5 Health Coverage

Medi-Cal Coverage

Are you enrolled in Medi-Cal?*

Yes, I am enrolled   I applied, but was denied   No, I was dis-enrolled

I am still awaiting a decision about my Medi-Cal eligibility   No, I never applied

I do not know

If "Yes, I am enrolled" is selected, please answer the following questions**

What type of Medi-Cal are you enrolled in?

Medi-Cal Expansion   Standard Medi-Cal   I do not know

If "Medi-Cal Expansion" is selected, please answer the following questions**

Effective Start Date____________Effective End Date____________

Medi-Cal Benefits Identification Card (B I C) Number ____________________

If "Standard Medi-Cal" is selected please answer the following questions**

Effective Start Date____________Effective End Date____________

Medi-Cal Benefits Identification Card (B I C) Number____________

Do you have a Medi-Cal Share of Cost (SOC)?   Yes   No   I do not know

If "No, I was dis-enrolled" is selected, please answer the following questions**

What type of Medi-Cal were you dis-enrolled in?

Medi-Cal Expansion   Standard Medi-Cal

If "Medi-Cal Expansion" is selected, please answer the following questions**

Effective Start Date____________Effective End Date____________

What type of dis-enrollment did you receive?

I have income at or above 138% Federal Poverty Level

I am Medicare eligible

I have excess assets

I am employed or able to work

I am receiving Unemployment Insurance (UI)

I was denied within the past 12 months from Medi-Cal, Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI)

Other

Medi-Cal Coverage Continued

If “I am still awaiting a decision about my Medi-Cal eligibility” is selected, please answer the following questions**

Date you applied to Medi-Cal:______________

Medicare Coverage

Are you eligible for Medicare?* Yes No

If “Yes” is selected, please answer the following questions**

Are you enrolled in Medicare Part D Health Plan?

Yes, I am enrolled No, I was dis-enrolled No, I have never applied

If “Yes, I am enrolled” or “No, I was dis-enrolled” is selected, please answer the following questions**

Medicare Part D Plan Enrollment Start Date______________

Medicare Part D Plan Enrollment End Date______________

Private Insurance Coverage

Are you enrolled in private insurance?*

Yes, I am enrolled No, I am not enrolled No, my plan was terminated

If “Yes, I am enrolled” or “No, my plan was terminated” is selected, please answer the following questions**

What type of health insurance plan are you enrolled in? If your plan was terminated, what type of health insurance were you enrolled in?

Health insurance plan obtained through Covered CA

Private insurance plan obtained through health insurance provider or broker

Health insurance plan through employer

Private insurance through Spouse or Other

Private Insurance through Veteran’s Administrative Health Care (e.g. Tricare)

COBRA or Cal-COBRA

Other, please specify type of health insurance plan ____________________

Health Insurance Plan Name____________________Member ID ____________________

Plan Start Date__________________Plan End Date __________________

Section 6 Insurance

Would you like assistance with your insurance premiums?*

Yes, I would like assistance with my health insurance premiums

Yes, I would like assistance with my Medicare Part D premiums. If selected, Medicare Part D Premium Payment eligibility and payment start date will be determined using Medicare enrollment information from Section 5.

No, I would not like assistance

Notes

- The HIPP program must assist with the medical premium in order to assist with dental and vision premiums
- The HIPP program does not assist with stand-alone vision plans. The vision premium must be included with the medical or dental health insurance billing statement premiums
- Individuals with 100% Extra Help/Full Low Income Subsidy (L I S) are not eligible for the Medicare Part D Premium Payment Program.

If "Yes, I would like assistance with my health insurance premiums" is selected, please answer the following questions**

Medical

Health Insurance Payee Name?

Anthem Blue Cross

Blue Shield of California

Blue Shield of California Small Group

Conexis

Health Net

Kaiser

L.A. Care and Local Initiative

Molina Health Care of California

Delta Dental of California

Premier Access

Other, please specify other health insurance payee name____________________

Type of Policy: Individual Family

What is your net premium amount?_____________________

Member ID/Subscriber ID Number:_____________________

Account Number (if applicable):________________________

Policy Number/ Group Number (if applicable):_____________

Medical Continued

How often is your premium due?

Monthly Bi-Monthly Quarterly Annually

Plan Start Date:__________________Plan End Date:___________________

Type of coverage:

Covered CA Private COBRA Cal-COBRA Other

If “Covered CA” is selected, please answer the following questions**

What is your gross monthly premium amount?__________________

What is the maximum Advanced Premium Tax Credit?_________________

What is the maximum Advanced Premium Tax Credit amount you are taking?______________

What Covered CA metal did you select? Bronze Silver Gold Platinum

Dental

Yes, I would like to receive dental assistance. If checked, please answer the following questions below**

Dental Insurance Payee Name?

Anthem Blue Cross

Blue Shield of California

Blue Shield of California Small Group

Conexis

Health Net

Kaiser

L.A. Care and Local Initiative

Molina Health Care of California

Delta Dental of California

Premier Access

Other, please specify other Dental insurance payee name ____________________

Type of Policy: Individual Family

What is your net premium amount?___________________

Member ID/Subscriber ID Number:____________________

Account Number (if applicable):______________________

Policy Number/ Group Number (if applicable):___________

Dental Continued

How often is your premium due?

Monthly Bi-Monthly Quarterly Annually

Plan Start Date: ___________________ Plan End Date: ___________________

Vision

Yes, I would like to receive vision assistance. If checked, please answer the following questions**

Note: Standalone vision plans are not covered. Vision must be bundled with Medical or Dental for coverage.

Vision Insurance Payee Name?

Anthem Blue Cross

Blue Shield of California

Blue Shield of California Small Group

Conexis

Health Net

Kaiser

L.A. Care and Local Initiative

Molina Health Care of California

Delta Dental of California

Premier Access

Other, please specify other health insurance payee name_______________________

How often is your premium due?

Monthly Bi-Monthly Quarterly Annually

Plan Start Date:_____________________Plan End Date:_____________________

Section 7 Read and Sign this Application

Temporary Access Period (TAP) Request

To request a temporary access period, the information below must be completed by the applicant/client who failed to provide the supporting eligibility documentation.

Please complete the application sections below:

Proof of Identification

I will provide my ADAP Enrollment worker with identification.

Proof of California Residency

I will provide proof of my California residency to my ADAP Enrollment worker.

Diagnosis Form

MY HIV positive status qualifies me for the ADAP program. I will provide my ADAP enrollment worker with a completed Diagnosis Form, a letter from my physician, or lab values including a recent Viral Load and CD4, if applicable.

Income

I will provide proof of my household income to my ADAP enrollment worker.

Proof of Medi-Cal Determination

I will apply for, and provide proof to my ADAP enrollment worker of Medi-Cal determination.

By signing below, I hereby certify that the above information is factual, accurate, and complete. I understand that I have a temporary access period in which to provide the necessary documentation to substantiate my qualifying ADAP information as stated above and that failure to comply within the allotted temporary access period will result in my ineligibility until such proof is provided. I also understand that ADAP is permitted to request additional verification documentation if the submitted documentation appears to be inconsistent or incorrect. I agree to promptly notify the program of any changes in my income, residency and health coverage. I understand that failure to provide accurate information or deliberately omit information may result in suspension or termination of services and I may be held financially responsible for any covered services obtained.

____
Applicant's or ADAP approved designated agent's signature

____
Date

Section 7 Read and Sign Application Continued

Penal Code and California False Claims Act

ADAP clients who knowingly provide inaccurate or false documentation may be in violation of various Penal Code laws and the California False Claims Act.

By signing below, I agree to the best of my knowledge that I provided accurate and true information when applying for or submitting eligibility or claim information to ADAP.

____

Applicant's or ADAP approved designated agent's signature

____

Date

Section 8 ADAP Enrollment Worker Information

Enrollment Worker Name*________________________

Phone Number*____________________Email address*_________________________

Enrollment Site Name*______________________

Enrollment Site Number*________________County*_______________________

State of California
Health and Human Services Agency

California Department of Public Health

AIDS Drug Assistance Program Consent Form

Consent to Participate and Consent to Release Personal and Medical Information

The AIDS Drug Assistance Program (ADAP) is a subsidy program administered by the California Department of Public Health (CDPH) to provide prescription drug treatments and other health services to persons infected with human immunodeficiency virus (HIV). ADAP includes prescription drug assistance and insurance assistance programs. Individuals applying for ADAP services must meet eligibility standards. Services are only available to persons who reside in California, are uninsured or underinsured, are not fully covered by Medi-Cal and have a modified adjusted gross income up to 500 percent of federal poverty level, based on family size and household income. To verify eligibility for this program, CDPH or its agents may be required to obtain personal information from other agencies or health care providers. If you decide to enroll in ADAP, the enrolling agency will collect personal information including your name, date of birth, address, social security number, medical history (including viral load and CD4 count records), and financial eligibility for the program. The information will be considered confidential, but may be exchanged with health care providers, CDPH staff, ADAP enrollment workers, the Department of Health Care Services (DHCS), Franchise Tax Board (FTB), Covered California, CDPH contractors associated with the administration of the program, the Surveillance, Research & Evaluation Branch of CDPH, and other governmental or public agencies as necessary for the limited purposes of administering the program and determining program eligibility. Information that you provide for you're ADAP application may also be made available to your local health department for statistical and research purposes. This information includes, but is not limited to, gender, ethnicity, zip code, diagnosis status, and date of birth. This information may also be used for research and professional writings under strict assurances that all identifying information including, name and social security number, is deleted. Any professional or research reports that may be published will not use your name nor any personal identifying information. Confidentiality agreements are in place which keep client information confidential except with specific client consent or as otherwise allowed by law.

For those specifically enrolled in, or applying for, the insurance assistance programs within ADAP, which provides health insurance premium payment and medical out-of-pocket cost payment assistance to eligible ADAP clients, CDPH or its agents may also be required to obtain and exchange personal and medical information, as described in the above paragraph, with health insurance plans, Consolidated Omnibus Budget Reconciliation Act (COBRA) administrators, employers and employer administered health insurance plans as necessary to determine your eligibility and for the purpose of administering the program.

I, ______________________, consent to release of personal and medical information to the applicable entities and for the purposes described above, as necessary for all of the ADAP program(s) for which I am enrolled in, or applying for services. I also consent for ADAP to obtain my viral load and CD4 count records from the Surveillance, Research & Evaluation Branch of CDPH to determine and maintain my eligibility and facilitate access to ADAP services.

This consent shall remain in effect for two (2) years from the date of my signature below. A photocopy of this consent shall be considered as valid as the original.

______________________	______________________	______________________
Applicant's Name (print)	Applicant's Signature	Date

The information requested on this form is required by the (a) California Department of Public Health, Human Resources Branch, Classification, Payroll & Selection Services for purposes of identification and document processing. (d) Furnishing the information requested on this form is mandatory. (f) Information requested on this form is used for benefits processing. (e) Failure to provide the mandatory information may result in benefit enrollment elections not being processed or being processed incorrectly.

(c) Legal references authorizing maintenance of this information include Government Code, Sections 1151 and 1153; Sections 6011 and 6051 of the Internal Revenue Code; and Regulation 4, Section 404.1256, Code of Federal Regulations, under Section 218, Title II of the Social Security Act. (g) This information may be transferred to other employing state agencies and campuses. (h) Employees have the right to review their own personal information maintained by the California Department of Public Health unless access is exempt by law. (b) Contact the California Department of Public Health, Chief of Human Resources Branch, Classification, Payroll, and Selection Services Section, 1501 Capitol Avenue, Suite 71-1501, P.O. Box 997378, Sacramento, CA 95899-7378, (916) 324-0219.