

# Application to Receive Allowable Services for HIV/AIDS Patient Care Programs:

- AIDS Drug Assistance Program (ADAP)
- AIDS Insurance Continuation Program (AICP)
- State Housing Opportunities for Persons with AIDS (HOPWA)
- Ryan White Title II Consortia and other Bureau HIV/AIDS Patient Care Programs

## **PART 1. Adult Applicant Information: HIV positive is an eligibility requirement. Check if you are HIV Positive.** **\_\_Y\_\_ \_\_N\_\_ \_\_Unknown.** Provide a copy of an HIV Laboratory Test which shows your HIV status.

Name: \_\_\_\_\_  
First M.I. Last Date of Birth (MM/DD/Year)  
Male\_\_ Female\_\_ Transgender\_\_ Race\_\_\_\_\_ Language\_\_\_\_\_

### **Check if you receive HIV/AIDS services from any of the following program(s):**

ADAP\_\_ AICP\_\_ HOPWA\_\_ TITLE II\_\_ TITLE I \_\_ COUNTY HEALTH DEPARTMENT\_\_ Other\_\_\_\_\_

**If you have a Case Manager, please provide the name & agency:** \_\_\_\_\_

**Are you a Veteran?** Yes \_\_ No\_\_ **Have you served in the Armed Forces?** Yes\_\_ No\_\_

**Are you Pregnant?** Yes \_\_ No\_\_ Don't Know\_\_\_\_\_

**Do you have a housing need?** Yes\_\_ No\_\_ **Do you rent?** Yes\_\_ No\_\_ **Do you own your house?** Yes\_\_ No\_\_

**How much is your monthly mortgage** \$\_\_\_\_\_ or rent \$\_\_\_\_\_

**Are you taking a prescription drug(s)?** Yes\_\_ No\_\_ If you can, please name or bring your prescriptions to your appointment

## **PART 2. Living Arrangements**

Address Where You Currently Live: \_\_\_\_\_  
Number Street Apt. Number

City State Zip County

Mailing Address:  
(if different)

Number Street Apt. Number

City State Zip County

Home Telephone: \_\_\_\_\_ Other Contact Telephone: \_\_\_\_\_

Work Telephone: \_\_\_\_\_ Name of Employer(s): \_\_\_\_\_

Email: \_\_\_\_\_

**How many adults live with you?** \_\_\_\_ (Spouse/Parents/Adult Children/Partner/Roommate, etc.)

**How many children live with you?** \_\_\_\_ (Under 18 years of age)

Check how you prefer staff contact you:

HOME PHONE\_\_ WORK PHONE\_\_ OTHER CONTACT PHONE\_\_ EMPLOYMENT PHONE\_\_ MAIL\_\_ OTHER\_\_

## **PART 3. Medicaid Insurance and Other Programs:**

### **Check if you receive services from the following programs:**

Medicaid \_\_ Medicare \_\_ Project AIDS Care \_\_ Veterans Administration \_\_\_\_\_ Children's Medical Services (CMS) \_\_\_\_

Other \_\_\_\_ (Name)\_\_\_\_\_

### **Are you currently receiving HIV/AIDS services from another local, state or federal public assistance program?**

Yes\_\_ No\_\_ If yes, which one(s):\_\_\_\_\_

**Do you have an existing health insurance policy?** Yes \_\_ No\_\_ **If Yes, is it through an employer?** Yes \_\_ No\_\_

**If NO, does your employer offer health insurance as a benefit?** Yes \_\_ No\_\_

**READ THE FOLLOWING BEFORE YOU COMPLETE PART 4 & 5**

PLEASE CHECK 4 IF YOU ARE PARTICIPATING IN ONE OF THE FOLLOWING PROGRAMS AND BRING THE AWARD OR ELIGIBILITY LETTER OR CARD AS PROOF.

- Medicaid
- Project AIDS Care (PAC)
- Food Stamps
- Temporary Assistance for Needy Families (TANF)
- Women, Infants and Children (WIC)
- Name Other: \_\_\_\_\_

**SKIP PARTS 4 & 5 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). This includes other adult persons living in the home, if they have joint financial arrangements with the applicant, such as banking (checking and savings) accounts, mortgage agreements, business or other personal finances. **DO NOT INCLUDE**, adults in the home with separate finances, live-in aides or persons under 16 years of age.

**HOUSEHOLD MONTHLY INCOME BEFORE TAXES AND DEDUCTIONS**

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						
Total Monthly Household Income						\$ _____	

\*If you checked NO INCOME provide a statement as to how food, clothing and shelter are being provided for you.

**PART 5. Cash and Items of Value**

- Do you have a checking bank account? Yes \_\_\_ No \_\_\_ If yes, how much? \$ \_\_\_\_\_
- Do you have a savings bank account? Yes \_\_\_ No \_\_\_ If yes, how much? \$ \_\_\_\_\_ How many cars do you have? \_\_\_\_
- Do you have more than 1 home? Yes \_\_\_ No \_\_\_ Do you own property (other than your personal residence)? Yes \_\_\_ No \_\_\_
- Do you own a business? Yes \_\_\_ No \_\_\_ Name and Address: \_\_\_\_\_
- List other items of value such as Certificates of Deposits, Treasury Bills Other: \_\_\_\_\_

**PART 6. Rights and Responsibilities (Please Initial by Each Item Below)**

- I understand that I am responsible for giving truthful and correct information on this application and during the application process to the best of my knowledge and 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 pay the Department of Health back for services.
- I understand the information I provide may be verified, which 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 towards staff.
- I understand the Department of Health, eligibility 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 on my case was unfair or incorrect.

**SIGNATURE REQUIRED** \_\_\_\_\_ **Date** \_\_\_\_\_

**FOR ELIGIBILITY STAFF ONLY**

Date Stamped Receipt of Application: \_\_\_\_\_ Walk-In \_\_\_ Mail \_\_\_ Other \_\_\_\_\_  
 Date of Appointment: \_\_\_\_\_ Eligibility Staff: \_\_\_\_\_  
 Date Determined Eligible: \_\_\_\_\_ Date Referred to: Case Management \_\_\_ ADAP \_\_\_ AICP \_\_\_ HOPWA \_\_\_ Other: \_\_\_\_\_ Date \_\_\_\_\_  
 Date Determined Ineligible: \_\_\_\_\_ Date Supervisory Review: \_\_\_\_\_ Fair Hearing Information Provided \_\_\_\_\_