

AIDS/HIV HEALTH INSURANCE PREMIUM SUBSIDY PROGRAM AND DRUG ASSISTANCE PROGRAM

APPLICATION/RECERTIFICATION

Before completing this form read APPLICATION/RECERTIFICATION Instructions

Check the program (s) for which you are applying: Health Insurance Premium Subsidy Program Drug Assistance Program

SECTION I. GENERAL INFORMATION

Last Name	First Name	Middle Initial	Date of Birth
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Social Security Number (Disclosure of your Social Security number (SSN) is voluntary, however most insurers and pharmacies use the SSN to identify policies and records. Supplying your SSN will expedite verification of insurance coverage and the processing of this APPLICATION/RECERTIFICATION.)

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If mailing address is different than street address give both addresses.

Street Address (House number, street name)				Mailing Address			
City	County	State	Zip	City	County	State	Zip

Home Telephone Number (Include area code)	Alternate/Cell/Work Telephone Number (Include area code)
_____ Is it all right to leave a message at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____ Is it all right to leave a message at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No

Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Male to Female <input type="checkbox"/> Transgender <input type="checkbox"/> Female to Male <input type="checkbox"/> Unknown	Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Living with a Partner	Veterans Status <input type="checkbox"/> Veteran <input type="checkbox"/> Not a Veteran Pregnancy Status <input type="checkbox"/> Pregnant <input type="checkbox"/> Not pregnant <input type="checkbox"/> Unknown	Race <input type="checkbox"/> Caucasian (White) <input type="checkbox"/> African American (Black) <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander/Hawaiian Native <input type="checkbox"/> Native American/Alaskan Native <input type="checkbox"/> Other _____	Ethnicity <input type="checkbox"/> Hispanic or Latino/a <input type="checkbox"/> Not Hispanic or Latino/a Preferred Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____
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Residency (Attach supporting documentation according to instructions) Resident of Wisconsin Not a resident of Wisconsin

Name of Case Manager	Agency Name and Telephone Number
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Employment Status (Check which best describes your current employment status) At least one box must be checked.

<input type="checkbox"/> Employed Full-time	<input type="checkbox"/> Temporary Medical Disability Leave	<input type="checkbox"/> Not Employed Due to Illness
<input type="checkbox"/> Employed Part-time	<input type="checkbox"/> Reduced Work Hours Due to Illness	<input type="checkbox"/> Not Employed/Non-Medical Reason

Physician Information	Pharmacy Information
Physician Name	Pharmacy Name
Clinic Name	Contact Person
Street Address	Street Address
City	City
State	State
Zip Code	Zip Code
Telephone Number (Include area code)	Telephone Number (Include area code) Fax Telephone Number (include area code)

SECTION II. FINANCIAL INFORMATION

Use the space below to list all sources of income and the amount of monthly gross income from each source. You must attach proof of the income listed below. **Attach a copy of the most recent benefits, paycheck stub(s), copy of your latest tax return, W-2 form, or a copy of your social security disability determination letter whichever most accurately provides proof of your current income. Failure to include proof of income will delay or prevent your enrollment in these program(s).**

Source (Monthly)	Self	Spouse	Total
Gross wages and salary			
Social Security Disability Income (SSDI)			
Social Security Supplemental Income (SSI)			
Dividends and interest			
Estate/trust income, net rental income, and/or royalties			
Public assistance			
Pensions, annuities, and/or veteran's pension			
Unemployment and/or worker's compensation			
Child/family support/alimony			
TOTAL OF ALL SOURCES			
FAMILY SIZE – Include yourself, spouse and/or legal dependents			

If you have no income, you must indicate how you are supported (i.e., relatives, friends). Failure to include this information may delay the APPLICATION/RECERTIFICATION process

SECTION III. INSURANCE COVERAGE INFORMATION

Check all boxes that describe your health insurance status. **At least one box must be checked.**

- No health insurance of any kind
- Medicaid coverage (Title 19, MA, BadgerCare Plus).
- Medicare coverage (Part A/ B) Medicare Part D
- Wisconsin Health Insurance Risk Sharing Plan (HIRSP) Major Medical Policy.
- HIRSP Medicare supplement insurance
- Medicare supplement insurance other than HIRSP
- An individual insurance policy other than HIRSP
- A group insurance policy provided by an employer
- COBRA or similar continuation coverage
- Dental insurance or coverage for routine dental care through health insurance
- Other

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(Include Medicaid number)

Insurance Policy Information (If you have health insurance, please fill out the following sections. Most of this information can be found on your insurance card.

Policy Number	Policy Begin Date	Policy End Date
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Insurance Company Information

Name of Insurance Company	Customer Service Telephone Number
Insurance Company Address	City
State	Zip Code

Prescription Drug Coverage

Does this policy cover prescription drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	What is your dollar amount for copay per prescription?	Brand
		Generic
What is your annual drug deductible?	What is your percentage of copay per prescription?	%
Does your policy have a maximum annual out-of-pocket contribution from you for drugs? If so, how much?		

Employer/Group Information

Employer/Group Name	Employer/Group Number		
Street Address	City	State	Zip

Policyholder Information (If different than self)

Name (Last, First, MI)

Street Address

City

State

Zip

Telephone Number

Social Security Number (Optional)

Medicare Part D Information (Clients that have prescription drug coverage under Medicare Part D, please fill out the following sections. Most of this information can be found on your Medicare Part D insurance card.)

Policy Number

Policy Begin Date

Policy End Date

Name of Part D Prescription Drug Plan

Customer Services Telephone Number

Part D Prescription Drug Coverage

What is your annual drug deductible?

What is your percentage %
or dollar amount copay per prescription?

Does your policy have a maximum annual out-of-pocket contribution from you for drugs? If so, how much?

Premium Payment Information

If applying for the health insurance premium subsidy program complete the following information about how your insurance premium is paid. Premiums are usually paid directly to the insurance company or to the former employer.

Please include a copy of your insurance premium notice or insurance premium payment coupons.

Name of Company the premium check will be made out to:

Address where premium should be sent

Name of contact person receiving premium check

Telephone number of contact person

Regular Premium amount

Next Payment due

Regular due date

Premium is paid

\$

Monthly Quarterly

If you need to make a payment that is different from the above information, please explain. Be specific about what is due and why, include the exact amount and due date:

NOTE: For Health Insurance Premium Subsidy Program only, if your income is between 201-300% of the federal poverty level, you will be required to make a 3% contribution toward the payment of your annual subsidy premium. The annual policy premium is determined by annualizing the first premium that is due for the benefit year. If applicable, information about your expected premium contribution will be forwarded to you in your approval letter.

IMPORTANT: If you are on a COBRA (or similar) extension, please include a copy of the letter from your former employer explaining your extension benefits. **OR** If you are regularly billed for your insurance, please send us a copy of your insurance bill or insurance premium payment coupons.

**AIDS/HIV HEALTH INSURANCE PREMIUM SUBSIDY AND DRUG ASSISTANCE PROGRAMS
AUTHORIZATION TO RELEASE INFORMATION**

I authorize the Wisconsin Department of Health Services (DHS) to receive and disclose medical information related to my HIV status to DHS staff, my designated pharmacy, my physician, my case manager, my private insurance company, the Health Insurance Risk Sharing Plan (HIRSP) and/or my employer as needed to determine my eligibility for benefits under either the Wisconsin AIDS/HIV Health Insurance Premium Subsidy or the Drug Assistance Programs and to administer these programs.

I hereby certify that all the information I have provided in this APPLICATION/RECERTIFICATION is true and complete. I understand that I am subject to losing my enrollment eligibility and possible prosecution under state and federal laws if this information is false.

SIGNATURE - Applicant or Guardian

Date Signed

Print Name of Applicant or Guardian

Return the completed APPLICATION/RECERTIFICATION and income verification in an envelope marked "**CONFIDENTIAL**" to:

Division of Public Health
Attn: Health Insurance Premium Subsidy and Drug Assistance Programs
P.O. Box 2659
Madison, WI 53701-2659

Or fax to (608) 266-1288

**AIDS/HIV DRUG INSURANCE PREMIUM SUBSIDY PROGRAM
AND DRUG ASSISTANCE PROGRAM
APPLICATION/RECERTIFICATION PART B – PHYSICIAN PORTION**

The AIDS/HIV Program will maintain all information on this form confidential.

APPLICANT INFORMATION

Last Name	First Name	Middle Initial	Date of Birth
Street Address			
City	State	Zip Code	

HIV SERUM ANTIBODY TESTS

EIA Results	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	Test Date	WB results	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	Test Date
Most recent CD4 count		Test Date	Most recent viral load		Test Date
If diagnosed with AIDS give date of diagnosis					

EMPLOYMENT STATUS

Has this patient had to reduce work hours because of illness or medical condition arising from or related to the individual's HIV infection? Yes No

Is this patient on a medical leave because of an illness or medical condition arising from or related to the individual's HIV infection? Yes No

Has this patient terminated work because of an illness or medical condition arising from or related to the individual's HIV infection? Yes No

PHYSICIAN INFORMATION

Name (Print or type)	Telephone Number (Include area code)	
Street Address		
City	State	Zip Code
SIGNATURE – Physician	Date Signed	

Return completed Part B of the APPLICATION/RECERTIFICATION in an envelope marked "**CONFIDENTIAL**" to:

Division of Public Health
Attn: Health Insurance Premium Subsidy and Drug Assistance Programs
P.O. Box 2659
Madison, WI 53701-2659

Or fax to (608) 266-1288