# AIDS/HIV DRUG ASSISTANCE PROGRAM AND INSURANCE ASSISTANCE PROGRAM APPLICATION/RECERTIFICATION – PART A

## SECTION I: GENERAL Fill out as much as possible.

| **Last Name** | **First Name** | **Middle Initial** | **Date of Birth (mm/dd/yy)** |
|---|---|---|---|
| | | | |

| Name You Use | Pronouns (he/she/they/etc.) |
|---|---|
| | |

| Language You Read | Language You Speak | Veteran Status |
|---|---|---|
| ☐ English ☐ Spanish ☐ Other:_____ | ☐ English ☐ Spanish ☐ Other:_____ | ☐ Veteran ☐ Not a Veteran |

**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 form.)

**Residency** (You must live in Wisconsin) ☐ I live in Wisconsin ☐ I do not live in Wisconsin

**Employment** (Current job status) ☐ Employed Full-time ☐ Employed Part-time ☐ Unemployed or Retired

## ADDRESS *Attach proof of address.* *Proof must show your name, street address, be valid and/or from the last 6 months.*

Example: Current ID card, most recent check stub, current lease or bill, unemployment benefits letter, or letter from your case manager.

| Street Address | Apt No. | Mailing Address (if different) | Apt No. |
|---|---|---|---|
| | | | |

| City | County | State | Zip Code | City | County | State | Zip Code |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

| Main Phone | OK to leave message? | Cell Phone | OK to leave a message? |
|---|---|---|---|
| | ☐ Yes ☐ No | | ☐ Yes ☐ No |

| Email | Best way to contact you: |
|---|---|
| | ☐ Phone ☐ Email |

## DEMOGRAPHICS Check at least one box in each section below: gender, marital status, race, and ethnicity.

| Gender | Marital Status | Race | Ethnicity |
|---|---|---|---|
| ☐ Cis female<br>☐ Cis male<br>☐ Gender non-conforming (GNC)<br>☐ Trans female<br>☐ Trans male<br>☐ Self-described (please specify):<br>_____ | ☐ Never married<br>☐ Married<br>☐ Living with partner<br>☐ Divorced<br>☐ Legally separated<br>☐ Widowed | ☐ Caucasian (White)<br>☐ African American (Black)<br>☐ Asian<br>☐ Asian Indian<br>☐ Chinese<br>☐ Filipino<br>☐ Japanese<br>☐ Korean<br>☐ Vietnamese<br>☐ Other:_____<br>☐ Native Hawaiian or Pacific Islander<br>☐ Native Hawaiian<br>☐ Guamanian or Chamorro<br>☐ Samoan<br>☐ Other: _____<br>☐ American Indian/ Alaskan Native<br>☐ Other: _____ | ☐ Non-Hispanic<br>☐ Hispanic<br>☐ Mexican, Mexican American, or Chicano/a<br>☐ Puerto Rican<br>☐ Cuban<br>☐ Another Hispanic, Latino/a, or Spanish Origin<br>☐ Unknown |

## CARE TEAM Fill out Case Manager information if you have one. Fill out what pharmacy you use and what doctor you go to.

| **Case Manager Name** | Case Management Agency | | |
|---|---|---|---|
| | | | |

| **Pharmacy Name** | Pharmacy Address | City | State | Zip Code |
|---|---|---|---|---|
| | | | | |

| **Doctor Name** | Clinic Name and Address | City | State | Zip Code |
|---|---|---|---|---|
| | | | | |

**SECTION II: INCOME** ***Attach proof of income.*** *Proof must show your name and date within 60 days for pay stubs, current year for benefits.* Example**:** Copy of pay stub(s), benefits letter (unemployment, SSDI/SSI, etc.), most recent W-2s, or letter from your case manager. If you have non-wage income, use latest tax return. If you are self-employed, use latest tax return and Schedule C.

| **Monthly Income** | **Yourself** | **Your Spouse** | **Total** |
|---|---|---|---|
| | $ | $ | $ |
| **If you are married, does your spouse have income?** | | ☐ Yes (Include proof of spouse income.)<br>☐ No | |
| **If you have no income, who supports you?**<br>Example: Relatives, friends, shelter, or community. | | **I am supported by:** | |

**Household Size** If your household size is more than 1, list your spouse and/or legal dependents. Use more paper if needed.

| Name of Household Member | Birth Date | Relationship to Applicant | Claimed on Taxes? |
|---|---|---|---|
| | | | ☐ Yes ☐ No |
| | | | ☐ Yes ☐ No |
| | | | ☐ Yes ☐ No |

**SECTION III. INSURANCE** What kind of insurance do you have? Check at least one box.

| | | |
|---|---|---|
| ☐ No health insurance | ☐ Medicare Coverage (Part A/B) | ☐ Medicaid (Medicaid, Title 19, MA) |
| ☐ Silver plan through marketplace (ACA) | ☐ Medicare Part C (Medicare Advantage) | ☐ BadgerCare Standard Plan (BCSP) |
| ☐ Insurance through work* | ☐ Medicare Part D (Prescription) | Have you applied in the last 30 days? |
| ☐ COBRA | ☐ Medicare Supplement – Basic Plan | ☐ Yes ☐ No |
| ☐ Dental Plan | ☐ Medicaid Purchase Plan (MAPP) | |

*If you have insurance through work and we pay you for the cost, send in your pay stubs for on a regular basis for payment.

**Insurance Premium Payment** Fill out if you have an insurance premium for ADAP to pay. Attach insurance paperwork if you have it. Use more paper if you have more policies.

| **Insurance Company** | | Type of plan (Silver, Part D, Dental, etc.) |
|---|---|---|
| Payment Mailing Address | | |
| Payment Amount | Next Payment Due Date | Premium amount listed is for one<br>☐ Month ☐ Quarter ☐ Year |

## AIDS/HIV DRUG ASSISTANCE AND INSURANCE 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 and/or my private insurance company as needed to determine and maintain my eligibility for benefits under the Wisconsin AIDS/HIV Drug Assistance Program and/or Insurance Assistance Program and to administer these programs. I understand that this information will be disclosed confidentially to a third party vendor for claims processing and/or insurance premium payments and administrative purposes.

I understand that if ADAP/IAP pays my insurance and I receive a refund or rebate from my insurance company, that ADAP/IAP is owed those funds. By signing this document, I agree to send any refund or rebate to ADAP.

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 termination of my enrollment eligibility and possible prosecution under state and federal laws if this information is false.

| **SIGNATURE of Applicant or Guardian** | | **Date Signed** | |
|---|---|---|---|
| Print Name of Applicant or Guardian | | | |

***Send the complete form and required documents marked "Confidential" to:***
Mail to Division of Public Health, Attn ADAP, PO BOX 2659, Madison WI 53701-2659; or fax to 608-266-1288.

***Important: Send proof of your address and proof of income with this form, or it cannot be processed.***