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

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

SECTION I. GENERAL INFORMATION

Last Name	First Name	Middle Initial	Date of Birth

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)

☐☐☐ - ☐☐ - ☐☐☐☐

Contact Information

You must attach proof of residency to show you live at the address listed below. Examples to attach: ID card, DMV issued ID, most recent check stub from employer with address included, most recent bill in your name, most recent rental agreement or lease, most recent bank statement or most recent unemployment award/benefits statement. If you cannot provide any of those documents, we can accept a written statement from your case manager indicating they have conducted a home visit.

Street Address			Apt/Unit No.	Mailing Address (if different)			Apt/Unit No.
City	County	State	Zip	City	County	State	Zip

Home Telephone Number	Alternate/Cell Telephone Number
OK to leave message? ☐ Yes ☐ No	OK to leave message? ☐ Yes ☐ No

Gender

☐ Male
☐ Female
☐ Transgender (Male to Female)
☐ Transgender (Female to Male)
☐ Unknown

Marital Status

☐ Never Married
☐ Married
☐ Living with a Partner
☐ Divorced
☐ Separated (legally)
☐ Widowed

Veterans Status

☐ Veteran
☐ Not a Veteran

Preferred Language

☐ English
☐ Spanish
☐ Other – specify:

_____

Race/Ethnicity (check all that apply)

☐ Caucasian (White)
☐ African American (Black)
☐ Asian
  ☐ Asian Indian
  ☐ Chinese
  ☐ Filipino
  ☐ Japanese
  ☐ Korean
  ☐ Vietnamese
  ☐ Other Asian

_____

☐ Native Hawaiian/Pacific Islander
  ☐ Native Hawaiian
  ☐ Guamanian or Chamorro
  ☐ Samoan
  ☐ Other Pacific Islander

_____

☐ American Indian/ Alaskan Native
☐ Other – specify:

_____

☐ Non-Hispanic
☐ Hispanic
  ☐ Mexican, Mexican American, or Chicano/a
  ☐ Puerto Rican
  ☐ Cuban
  ☐ Another Hispanic, Latino/a, or Spanish Origin
  ☐ Other

_____

☐ Unknown

Residency (Attach proof of residency)

☐ Resident of Wisconsin ☐ Not a resident of Wisconsin

Case Management (if applicable)

Case Manager and Agency

Employment Status (Check which best describes your ***current*** employment status)

☐ Employed Full-time ☐ Employed Part-time ☐ Unemployed

SECTION II. FINANCIAL INFORMATION

	Self	Spouse	Total
Monthly Income	$	$	$

Please provide us with your current income information which shows the amount 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 (if self-employed or you have non-wage income), or a copy of your SSI/SSDI award letter whichever provides proof of your current income.**

If you have no income, you must indicate how you are supported (i.e., relatives, friends).	**I am supported by:**

If married, does your spouse have income? ☐ **Yes** ☐ **No**
If yes, please include proof of income.

Family Size

If your family size is more than 1, list your spouse and/or legal dependents. Use additional paper if necessary.

Name of Family Member	Birth Date	Relationship to Applicant	Claimed on Taxes?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

SECTION III. INSURANCE INFORMATION

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

☐ No health insurance of any kind
☐ Silver Plan through the Marketplace*
☐ A group insurance policy provided by an employer
☐ Other_____
☐ Medicare coverage (Part A/B)
☐ Medicare Part D (Prescription Drug Coverage)*
Do you have extra help to pay your premium? ☐ Yes ☐ No
If so, please provide the amount you need ADAP to pay below.
☐ BadgerCare Standard Plan (BCSP)
Have you applied for BCSP in the last 30 days? ☐ Yes ☐ No
☐ Medicaid coverage (Medicaid, Title 19, MA)
☐ Individual policy purchased outside of the Marketplace*
☐ COBRA or similar continuation coverage*
☐ Medicaid Purchase Plan (MAPP)*
☐ Medicare supplement insurance – Basic Plan*

Do you have insurance through an employer? ☐ Yes ☐ No

If yes and we pay you back for the cost of the insurance premiums being taken from your check, you do not need to complete the three lines below. Be sure to send in your pay stubs for reimbursement on a regular basis.

Insurance Premium Payment Information

Complete below if you have an insurance premium for ADAP to pay.

Company the insurance premium payment goes to

Address where insurance premium should be sent

Cost of Premium*	**Next Payment Due**	Premium is paid: ☐ **Monthly** ☐ **Quarterly**

Physician Information			Pharmacy Information		
Physician Name			Pharmacy Name		
			Contact Person		
Street Address			Street Address		
City	State	Zip Code	City	State	Zip Code
Telephone Number			Telephone Number	Fax Number	

At this time, please review your application to make sure you did not leave any required information blank.

Did you remember to include:

- ☐ **Proof of income**
- ☐ **Proof of residency**
- ☐ **Spouse's verification documents**

If you did not include the required documents with your application your program eligibility will be delayed. Please be sure to include the information requested.

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, my private insurance company and/or my employer 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 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

Return the completed Application/Recertification and required documents in an envelope marked "CONFIDENTIAL" to:

Division of Public Health
Attn: ADAP
PO Box 2659
Madison, WI 53701-2659

or you may fax it to: (608) 266-1288

Clear / Reset Form