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

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: ID card, most recent check stub showing your address, most recent bill in your name, most recent lease or unemployment award/benefits letter. You can also send a letter from your case manager stating they have made a home visit.

Street Address			Apt/Unit No.	Phone Number	OK to Leave a Message? ☐ Yes ☐ No
City	County	State	Zip	Cell Phone Number	OK to Send a Text Message? ☐ Yes ☐ No
Mailing Address (if different)			Apt/Unit No.	E-mail Address	
City	County	State	Zip	Preferred Name	Pronouns

Gender

- ☐ Cis female
- ☐ Cis male
- ☐ Gender non-conforming (GNC)
- ☐ Trans female
- ☐ Trans male
- ☐ Prefer to self-describe (please specify: _____)

Marital Status

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

Veterans Status

- ☐ Veteran
- ☐ Not a Veteran

Preferred Language

- ☐ English
- ☐ Spanish
- ☐ Other: _____

Race (Check all that apply)

- ☐ Caucasian (White)
- ☐ African American (Black)
- ☐ Asian
  - ☐ Asian Indian
  - ☐ Chinese
  - ☐ Filipino
  - ☐ Japanese
  - ☐ Korean
  - ☐ Vietnamese
  - ☐ Other: _____
- ☐ Native Hawaiian/Pacific Islander
  - ☐ Native Hawaiian
  - ☐ Guamanian or Chamorro
  - ☐ Samoan
  - ☐ Other: _____
- ☐ American Indian/ Alaskan Native
- ☐ Other: _____

Ethnicity (Check all that apply)

- ☐ 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 address)

☐ Resident of Wisconsin ☐ Not a Resident of Wisconsin

Case Management (if applicable)

Case Manager and Agency

Employment Status (Check your ***current*** employment status)

☐ Employed Full-time ☐ Employed Part-time ☐ Unemployed/Retired

SECTION II. FINANCIAL INFORMATION (Attach proof of income)

	Self	Spouse	Total
Monthly Income	$	$	$

Send a copy of the most recent benefits, unemployment benefit letter, paycheck stub(s), copy of your most recent W-2's, copy of your latest tax return (if self-employed or have non-wage income), or a copy of your SSI/SSDI award letter as proof of your current income.

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

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

Family Size (If your family size is more than 1, list your spouse and/or legal dependents. Use extra paper if needed.)

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

SECTION III. INSURANCE INFORMATION (Check all boxes that describe your health insurance.)

Check at least one box.

☐ No health insurance
☐ Silver plan through the marketplace
☐ Group insurance provided by an employer*
☐ Medicare Coverage (Part A/B)
☐ Medicare Supplement Insurance – Basic Plan
☐ BadgerCare Standard Plan (BCSP)
Have you applied for BCSP in the last 30 days? ☐ Yes ☐ No
☐ Medicaid Coverage (Medicaid, Title 19, MA)
☐ Medicaid Purchase Plan (MAPP)
☐ COBRA
☐ Medicare Part D (Prescription Drug Coverage)
☐ Other_____

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

Insurance Premium Payment Information (Fill out below if you have an insurance for ADAP to pay.)

Insurance Company

Mailing Address for Payment

Payment Amount	**Payment Due Date**	**Due Date**
		☐ Monthly ☐ Quarterly ☐ Annually

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

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

Important Notice: If you do not include proof of your address and proof of income with this form, it will not be processed.

Send the complete form and required documents in an envelope marked “Confidential” to:

Division of Public Health
Attn: ADAP
PO Box 2659
Madison, WI 53701-2659
Fax: 608-266-1288

Clear / Reset Entire Form