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.)

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.)	

Language You Read	**Language You Speak**
☐ English ☐ Spanish ☐ Other: _____	☐ English ☐ Spanish ☐ Other: _____

Pregnancy Status	**Veteran Status**
☐ Pregnant ☐ Not Pregnant or Does Not Apply	☐ Veteran ☐ Not a Veteran

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? ☐ Yes ☐ No	Cell Phone	OK to leave a message? ☐ Yes ☐ No

Email	Best way to contact you: ☐ Phone ☐ Email

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

Demographics

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

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

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.) ☐ No		
If you have no income, who supports you? 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
			☐ Yes ☐ No

Section III. Coverage

Have you applied for or are you getting help from other programs?

Medicaid (BadgerCare)	☐ Yes	☐ No	☐ Not eligible/does not apply to me
Medicare Part D (Prescription coverage)	☐ Yes	☐ No	☐ Not eligible/does not apply to me
Low Income Subsidy (LIS)/Extra Help for Medicare Part D	☐ Yes	☐ No	☐ Not eligible/does not apply to me
Employer Sponsored Health Insurance (Insurance through work)	☐ Yes	☐ No	☐ Not eligible/does not apply to me
Private or Commercial Insurance (ACA, Marketplace, Dental, etc.)	☐ Yes	☐ No	☐ Not eligible/does not apply to me

Section IV. Insurance

What kind of insurance do you have? Check at least one box.

☐ No health insurance	☐ Medicare Coverage (Part A/B)
☐ Silver plan through marketplace (ACA)	☐ Medicare Part C (Medicare Advantage)
☐ Insurance through work	☐ Medicare Part D (Prescription)
☐ COBRA	☐ Medicare Supplement – Basic Plan
☐ Dental Plan	☐ Medicaid Purchase Plan (MAPP)
☐ BadgerCare Standard Plan (BCSP)	☐ Medicaid (Medicaid, Title 19, MA)

Insurance Premium Payment

Fill out if you have an insurance premium for HDAP to pay. Attach insurance paperwork if you have it. Use more paper if you need to.

Insurance Company			Type of plan (Silver, Part D, Dental, etc.)
Payment Mailing Address			
Plan Start Date	Next Payment Due Date	Payment Amount $	Premium amount listed is per ☐ Month ☐ Quarter ☐ Year

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

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: Send proof of your address and proof of income with this form, or it cannot be processed.
Send the complete form and required documents marked "Confidential" to:
Mail to Division of Public Health, Attn HDAP, PO BOX 2659, Madison WI 53701-2659; or fax to 608-266-1288.

Application Checklist

Make sure these things are included with your application so that it can be accepted:

- ☐ Proof of income (and proof of spouse income, if applicable)
- ☐ Proof of street address
- ☐ Name and contact information
- ☐ Marital status and other demographics
- ☐ Insurance and coverage information, if applicable
- ☐ Signature and date