GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF HEALTH

APPLICATION FOR HEALTH SERVICES

INCLUDING DC ADAP, COBRA, AND MEDICAID EXPANSION

Administered by the District of Columbia Department of Health

Please FAX this application and all supporting material to:

(202) 673-4365

Note: After you have completed the application, please refer to this checklist to ensure that your application is complete. Your application will not be processed unless all of the required documents are attached.

- Completed application forms (4 pages)
- HIV status (only **one** of the following is necessary)
  - Doctor's or Case manager's signature (on p.4).
- Residency verification documents (only **one** of the following is necessary)
  - Copy of utility bill or a letter from a government agency with your DC address listed
  - Voter registration card
  - DC driver's license, or non-driver's identification
  - Lease or mortgage agreement
  - If you are homeless, please have case manager provide support documentation on facility letterhead.
- Income/Work Documentation (only **one** of the following is necessary)
  - Wages (at least one month of pay stubs or letter from employer stating hours worked and wages paid); or
  - Income (Social Security/public assistance/unemployment/Veteran's benefits/pension check stub or award letter).
- Asset Documentation (all that are applicable) **Asset Limit is $25,000**
  - Checking Account;
  - Savings Accounts;
  - Certificates of Deposit; Stocks/Bonds; or Mutual Funds/Trusts.
- Insurance Information (if applicable), including Health Insurance/Medicare Part D card or letter from insurance company, proof of monthly premium, deductible, or co-payment amount(s) as needed
- To be considered for the Medicaid Waiver, please provide one of the following:
  - Original birth certificate (case manager can provide signed attestation that he or she viewed original and submit a copy)
  - Submit a request for the District's Income Maintenance Administration to locate the original birth certificate
  - Certificate of Citizenship or Naturalization
  - Copy of a green card or other documentation that includes the A number
- COBRA documentation (if applicable), including COBRA eligibility letter from employer, billing statement, and proof of up to three (3) months of paid premiums for reimbursement (if applicable)

❑ New Application
❑ Recertification

APPLICATION FOR HEALTH SERVICES

Administered by the District of Columbia Department of Health

For Office Use Only:
Program_____
Group_____
Location Code _____

Section I: Basic Information

Last Name	First Name				Middle
Social Security Number	Date of Birth		Phone		
Street Address	Apt #	City	State	Zip	Ward #
Mailing Address (if different)	Street	Apt #	City	State	Zip
Case Manager	Facility	Phone	Fax		

Please check the appropriate boxes for each question

Ethnicity ❑ Non - Hispanic

Race:
❑ White ❑ Black/African American
❑ American Indian or Alaskan Native
❑ African ❑ Asian
❑ Multi-Racial
❑ Native Hawaiian or Pacific islander

Ethnicity ❑ Hispanic

Race:
❑ White ❑ Black/African American
❑ American Indian or Alaskan Native
❑ African ❑ Asian
❑ Multi-Racial
❑ Native Hawaiian or Pacific islander

Sex: ❑Male ❑Female ❑Transgender

How many dependents are living with you? _____

Are you pregnant? ❑ Yes ❑ No

How were you referred to DC ADAP?
❑ Doctor ❑ Friend
❑ Clinic ❑ Advertisement
❑ Case manager ❑ HIV Test Site
❑ Other (specify): _____

Section II: Employment, Income, and Asset Information

Check if you work either:

❑ 40 or more hours per month
❑ 120 hours or more in the last three months

Note: ***You must provide documentation of the hours worked (e.g., pay stubs, etc).***

Salary/wages	$ _____	Checking Account	$ _____
Disability Benefits	$ _____	Savings Account	$ _____
Public Assistance (GPA)	$ _____	Other (Mutual funds, CDs, Stocks/Bonds)	$ _____
Unemployment	$ _____	**Total Assets**	**$ _____**
Pension	$ _____		
Other: (please specify below)	$ _____		
_____			
Total Monthly Income	**$ _____**		

Name	Social Security Number	Date of Birth

APPLICATION FOR HEALTH SERVICES
INCLUDING ADAP AND MEDICAID EXPANSIONS

Section III: Clinical Information

Please list the person's current HIV drug regimen:

_____

_____

_____

_____

Is this person adherent to medications?

❑ Yes ❑ No ❑ Don't know

Would they benefit from additional adherence support?

❑ Yes ❑ No

Has there been a treatment interruption for this person?

❑ Yes ❑ No

If yes, please indicate any known reasons for this treatment interruption:

❑ Incarceration ❑ Intolerant of Side effects

❑ Substance use ❑ Used other insurance

❑ Moved out of DC ❑ Mental health issues

Section IV: Medicaid, Medicare, Private Health Insurance Information

Have you applied for Medicaid within the last 6 months?

❑ Yes ❑ No

If yes, please check one:

❑ Pending ❑ Denied(Provide denial letter)
❑ Approved ❑ On Medicaid Spend-Down

If you are currently on Medicaid or Spend-Down, please provide:

Medicaid #: _____
Spend down amount $ _____

Are you receiving any of the following benefits?

❑ TANF ❑ SSI ❑ SSDI

Medicare? ❑ Yes ❑ No

If yes, please provide a copy of Part D card

Are you receiving extra help with Medicare Part D costs? ❑ Yes ❑ No

If yes, please provide a copy of letter from Income Maintenance Administration regarding QMB status

Are you seeking assistance with out-of-pocket costs? If yes, please check all that apply:

❑ Premiums ❑ Co-Payments ❑ Deductibles

Do you have health insurance? ❑ Yes ❑ No

If yes, please provide a copy of your insurance card and the following information:

Health Insurance Company Address:

_____

_____

Contact Person: _____ Phone: _____

Have you met your prescription drug cap for the year?

❑ Yes ❑ No

Do you wish to be considered for coverage of your COBRA premiums?

❑ Yes ❑ No

(if yes, please provide a copy of insurance card along with supporting COBRA documentation)

Name	Social Security Number	Date of Birth

APPLICATION FOR HEALTH SERVICES
INCLUDING ADAP AND MEDICAID EXPANSIONS

CERTIFICATION STATEMENTS

Alternate Contact: I authorize DC MAA/HAA to speak with the following person or persons (e.g., relative, friend) about my application if you are not able to contact me. If at any time I wish to revoke this person's authorization, I will notify ADAP at (202) 671-4900.

Name	Phone Number	Relationship

Name	Phone Number	Relationship

Applicant Certification and Signature:

I certify that all of the information provided above is accurate and true. I authorize my healthcare provider to allow D.C. Medicaid and HIV/AIDS Administration officials access to (1) my healthcare records and other documents related to services rendered and (2) other pertinent medical information to the program for the purpose of determining my medical eligibility for programs and evaluation. Information may be shared between District agencies such as Medicaid, the Income Maintenance Administration, and the HIV/AIDS Administration in order to determine and process my eligibility for various programs.

I also understand and agree to the following:

- My participation is voluntary;
- Enrollment in the Medicaid Demonstrations are limited, and if the programs are already full at the time of my application I will be placed on a waiting list;
- If during the course of my enrollment in this program I become eligible for Title XIX or XXI (Medicaid/Healthy Families), I will be enrolled in the District Medicaid program in such a way that does not disrupt my continuity of care;
- DC MAA/HAA officials may contact my case manager to discuss information relevant to my application;
- DC MAA/HAA officials may verify the information on this form;
- DC MAA/HAA officials may contact my insurance company to verify my coverage; and
- This application will not be considered complete without supporting documentation including the submission of page 4 from a medical professional. Pending applications will be maintained for 90 days.

Further, I agree to inform the DC MAA/HAA office of any changes in my residency/address, income, Medicaid eligibility status and insurance coverage. Further, if I deliberately misrepresent information on my application, I may be required to repay benefits received under DC MAA/HAA, and I may be prosecuted under applicable District and federal law.

Applicant's Signature _____ Date _____

Name	Social Security Number	Date of Birth

APPLICATION FOR HEALTH SERVICES
INCLUDING ADAP AND MEDICAID EXPANSIONS

Section V: HIV Information *(To be Completed by a Medical Professional)*

Is the person named on this form HIV-infected?

❑ Yes ❑ No

Physician's Name:_____ DC License Number: _____

Most recent viral load results _____ Date _____

Most recent CD4 count _____ Date _____

Please indicate if this person's CD4 count has ever been below 200.

❑ Yes ❑ No

Is this person infected with Hepatitis C (HCV)?

❑ Yes ❑ No

Please indicate the number of hospitalizations in the past year _____

Yes, the applicant named on this form is HIV-infected or has previously been eligible for ADAP or other Ryan White-funded services.

To Be Completed by Physician/Case Manager

Name: _____ DC License Number/Facility: _____

Office Phone: _____ Office Fax: _____

Physician's/Case Manager's signature must be an original

_____ *Date:* _____

You may fax the application to:

(202) 673-4365