899 North Capitol Street, NE
Washington, DC 20002
Phone: (202) 671-4900
Fax: (202) 673-4365

Application & Instructions

AIDS Drug Assistance Program (ADAP)
Health Insurance Assistance Program

DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH
HIV/AIDS, HEPATITIS, STD, TB ADMINISTRATION

General Information

The D.C. Department of Health offers the following programs to provide access to health care (ADAP and the Health Insurance Assistance Program) for District of Columbia residents with HIV infection who are uninsured or underinsured. These programs use the same application form and enrollment process.

AIDS Drug Assistance Program (ADAP) pays for medications for the treatment of HIV/AIDS and opportunistic infections. The drugs paid for by ADAP can help people with HIV/AIDS live longer and treat the symptoms of HIV infection. ADAP can help people with no insurance, partial insurance, dual eligible (Medicaid, Medicare, Alliance) or Medicare Part D.

Health Insurance Assistance Program pays for your monthly copays and deductibles for medications on the District of Columbia ADAP drug formulary, and/ or insurance premiums, if you meet the eligibility criteria and are enrolled in a health insurance plan on your own or as part of a group (e.g., you have insurance through your job).

DC AIDS Drug Assistance Program Confidentiality Statement

Under District of Columbia Law, HIV related information provided to the DC ADAP is kept strictly confidential. Such information (i.e. that you are a participant) may be given to those parties necessary for the proper administration of the Programs. These are individuals and organizations with whom the Programs need to discuss your application and/or participation in order to determine eligibility, pay for services or drugs covered under the Programs, or properly account for the funds spent. Program staff is aware of a participant's need for confidentiality and privacy, and will discuss personal information only as strictly necessary for the administration of the Programs.

To provide you with an understanding of the issue of confidentiality and the conditions of participation in the Programs, the following examples are provided:

- The Programs will NOT contact your employer, landlord, family, friends, neighbors, or anyone else without direct consent from you; whether directly related to your application or participation in the Programs.
- The Programs may contact your doctor or health care provider to get more information or clarify information required on the Medical Eligibility Form.
- The Programs will verify to a pharmacy, or to a health care provider that you are enrolled and pay for the covered services or drugs when your Program letter, with your name and ID number, is shown to a pharmacy or health care provider.
- The Programs will discuss the application of individuals in prison with authorized employees of Parole or Corrections as needed to enroll in the Programs.

You may notify the Programs, in writing, of someone you want the Programs to contact if Program staff cannot contact you for more information (i.e. the social worker who is helping you to apply for the program).

The DC ADAP and the Health Insurance Assistance Program is the payer of last resort and will contact your health insurance company or other third party payer (i.e. drug manufacturer rebate program) who will reimburse ADAP for drugs provided to you under the Programs.

This is necessary for DC ADAP to recover funds which can be used to expand the Programs to cover new drugs/services and more people living with HIV infection.

These conditions are from the date of your application until your termination from the Programs, including the time needed to complete any third party reimbursement procedures for therapeutic drugs or services provided by the Programs. You may terminate your enrollment in the Programs in writing at any time.

If you have questions please call (202) 671-4900.

ALL INFORMATION PROVIDED TO THE PROGRAMS IS KEPT STRICTLY CONFIDENTIAL.

Application Instructions

Eligibility is based on financial and medical need.
Along with a complete application, documentation of residency, income and HIV status is required. The last page of the application must be submitted by a doctor.

Applications submitted with ALL required documentation are processed within two weeks. Incomplete applications and applications without supporting documentation will delay receipt of your enrollment approval letter and vital program information.

When you are approved, you will get an approval letter and instructions on how to use it. You must present this letter and a prescription at a participating pharmacy to receive covered medications at no charge.

I. Applicant Information

Name
List your full name, social security number and date of birth. If there is another name you are known by, put that in the space provided and tell us the name you want printed on your certification/recertification letter. Include your complete address.

Address
Proof of District of Columbia residency is required. Residency can be documented with a copy of ONE of the following (showing your name and address).

- Current lease or mortgage statement, or deed settlement agreement
- Current driver's license
- Current voter registration card
- Current Notice of Decision from Medicaid
- Fuel/utility bill (past 90 days)
- Property tax bill or statement (past 60 days)
- Rent receipt (past 90 days)
- Pay stubs or bank statement with your name and address (past 30 days)
- Letter from another government agency addressed to applicant
- Active (unexpired) homeowner's or renter's insurance policy
- DC Healthcare Alliance Proof of DC Residency form
- If homeless, please provide statement from case manager or facility letterhead

If you have a PO Box where you receive your mail you must include information documenting your physical address to document District of Columbia residency.
If you live with someone and have none of the items below in your name, we will need proof of their residency and a letter stating that you live with them:
Sex/Race/Ethnicity/Language
Please check your sex, race, ethnicity and language preference.

Registered Voter in the District of Columbia
Applicant should report if they are a registered voter in the District of Columbia

II. Living Arrangement

Household Members

List all household members. Anyone who is legally responsible to or for you is considered a household member. This includes a spouse and any children under 21 years old or parent and siblings if you are under 21 years old.

III. Income

Financial Eligibility
Financial eligibility is based on 500% of the Federal Poverty Level (FPL): FPL varies based on household size and is updated annually. Financial eligibility is calculated on the gross income available to the household.

Income Source
Check all sources of income for you and all household members. This is income only for household members with whom you have a legal responsible relationship (for example, spouse or child but not uncle, cousin or roommate). For each source, indicate the gross amount, how often the income is received, and whether it is your income or a household member's.
Proof of income is required. Provide complete income documentation for each source of income checked.

For Wage Earners
Income should be documented by copies of pay stubs for the past 30 days. The paystub must show the year-to-date earnings, hours worked, all deductions and the dates covered by the paystub. If you cannot get a paystub, send us a notarized letter from your employer showing gross pay for the past 30 days along with a copy of your most recent income tax return. (The letter does not need to be addressed to the Programs. A letter addressed "to whom it may concern" is sufficient.)

Self-employed Individuals
Provide business records for the three months prior to application indicating type of business, gross income, net

income, and your most recent year income tax return. A notarized statement from you of projected current annual income must also be included.

Rental Income

Income you receive from rental property can be documented by a copy of the lease you have with your tenants and a copy of your most recent income tax return.

All Other Income

Copies of SSD/SSI award letters, unemployment checks, Social Security checks, pension checks, etc. from the past 30 days should be sent as proof of other types of income. If living off savings please provide a copy of bank statements, stocks, bonds, 401k, IRA etc.

No Income, Supported by Others

If you have no income and are supported by a friend or family member provide a letter from that friend or family member stating how they support you.

IV. Health Coverage

Applicant must include a copy of the front and back of all other health coverage cards.

Health Insurance Assistance Program Requirements

Clients must be enrolled in an insurance plan that includes HIV care (HIV care cannot be excluded as a pre-existing condition) and a comprehensive drug benefit.
DC ADAP will only pay for applicant's premium, not the premium for any of his or her family members. No payments will be made to the client directly; all payments will be made to the insurance company or employer. If ADAP is paying a client's premium to his or her employer (as part of a group plan), ADAP will only pay the employee's portion – not the entire premium. Premiums are paid on a monthly basis

Insurance Co-payment and Deductible Program Requirements

Coverage for all co-payments and deductibles are exclusively available for drugs on the DC ADAP formulary. Clients must utilize the DC Network pharmacies for coverage of co-payments and deductibles. Co-payments and/or deductibles cannot exceed monthly and annual cost units required by the DC ADAP program.

Medicaid/Alliance

Indicate your Medicaid Status or if you have DC Healthcare Alliance.

Medicare

Indicate if you have Medicare and if so, what type(s), A, B, C or D.

COBRA

The District will pay the COBRA premiums for the full life of the policy by paying the COBRA administrator. Clients are not eligible to receive any COBRA reimbursement payments paid on their own as this is not permissible usage of Ryan White funds as per Health Resources Services Administration (HRSA) legislations. COBRA documentation, including COBRA eligibility letter from employer, and billing statement will be required by DC ADAP.

Health Insurance

Be sure to answer all questions regarding health insurance. If you are having trouble making your health care premium payments please call (202) 671-4900.

V. HIV Information

Physician information

Name, DEA number, license number, Medicaid number, NPI number, hospital or facility name and address and office phone number.

Disease staging

Documentation of HIV infection including CD4 counts, viral loads, Hepatitis C and Date of Diagnosis

Disease History

Documentation of other infections, anti-retroviral treatment, PCP prophylaxis and immunizations

Alternate Contacts(s) and Signature

In order for Program staff to speak to someone on your behalf about your application, you must list them. Please read the confidentiality statement that describes who we may contact regarding your application and enrollment.

Carefully read the Certification Statement then sign and date the application.

Problems or Questions

If you have problems filling out the application or have questions about the DC ADAP Program, or any required documentation, please call (202) 671-4900 for assistance

We **cannot** process an application that is not signed. Make a copy of the application and all documentation for your records.

Government of the District of Columbia
Department of Health

ADAP APPLICATION CHECKLIST

Please use this list as a tool to verify all components of the ADAP application is complete prior to determining the client's eligibility. Check **yes or no** if the items are not included in the application packet. If you answer no to any of the following items the application is incomplete. All ADAP applications must be completed within 14 days in order to be processed for eligibility.

Section I: Applicant Information	Owner	Completion Date	YES	NO
(Name, Address, Contact Information, Social Security, Ethnicity, Case manager & Facility)				
Section II: Household	**Owner**	**Completion Date**		
(Members of household that you live with)				
Section III: Income	**Owner**	**Completion Date**		
Income (Salary, Income Source, Social Security/ Unemployment Benefits, Investment Holdings)				
Section IV: Healthcare Coverage	**Owner**	**Completion Date**		
(Medicaid, Medicare, Private Health Insurance Information, Certification Statements)				
Section V: HIV Information	**Owner**	**Completion Date**		
(To be completed by a Physician)				
Documentation			**YES**	**NO**
Copy of Insurance Card	**Owner**	**Completion Date**		
(Medicare Part D, COBRA, Health Exchange/ACA Insurance)				
Proof of Address	**Owner**	**Completion Date**		
(Utility Bill, Bank Statement, Government ID, or Official Letter From the Government. If person does not have a place of residency, must include a letter and utility bill from person they are living with)				
Proof of Income/ Work Documentation	**Owner**	**Completion Date**		
(Disability Statement, Pension Statement, Paystub, Letter from Employer)				

District of Columbia Department of Health

HIV/AIDS, Hepatitis, STD, and TB Administration

Aids Drugs Assistance Program

899 North Capitol Street N.E. 4th floor, Washington, D.C. 20002

For office use only:
Program_____
Group_____
Location Code_____
Eligibility Determination Date___/__/___

SECTION I: APPLICANT INFORMATION

Last Name		**First**		**M.I.**	**Other Name(s):**	**Date of Birth**	/ /
Street Address (*Proof of Residency Required*)				**Apartment/Unit #**			
City		**State**		**ZIP**			
Social Security No.		Can program information be sent to the address listed? YES ☐ NO ☐		**Mailing Address:**			
Phone		**E-mail Address**					
Case Manager:		**Facility:**		**Phone:**		**Fax:**	

Sex ☐ Male ☐ Female ☐ Transgender (Male to Female) ☐ Transgender (Female to Male)

Race ☐ White ☐ Black/African American ☐ Asian ☐ Hawaiian/ Pacific Islander ☐ Native American/Alaskan ☐ More than one race

☐ Other_____

If Asian, ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian

If Native Hawaiian, Pacific Islander, ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐Other_____

Ethnicity ☐ Hispanic ☐ Non-Hispanic

If Hispanic/Latino ☐ Mexican, Mexican-American ☐ Chicano ☐ Puerto Rican ☐ Cuban ☐ Other Hispanic Origin

Language ☐ English ☐ Spanish ☐ Other_____

Are you currently pregnant? ☐ Yes ☐ No ☐ Not Applicable ☐ Unknown

Are you a veteran (Optional)*?* ☐ Yes ☐ No

Are you a registered voter in the District of Columbia**?** ☐ Yes ☐ No

Relationship Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Partnered ☐ Widowed

SECTION II: HOUSEHOLD

☐ Live Alone ☐ Live with others (complete below) ☐ Homeless/Shelter ☐ Corrections Release

Household Member's Name	Sex	Date of Birth	Relationship	Lives with you
1._____	☐ M ☐ F ☐ T	___/___/____	_____	☐ Yes ☐ No
2._____	☐ M ☐ F ☐ T	___/___/____	_____	☐ Yes ☐ No
3._____	☐ M ☐ F ☐ T	___/___/____	_____	☐ Yes ☐ No
4._____	☐ M ☐ F ☐ T	___/___/____	_____	☐ Yes ☐ No

SECTION III: INCOME INFORMATION (*Proof of income required for applicant and household)*

Income Source (check all that apply)

☐ Salary/Wages: ☐ FT ☐ PT ☐ Public Assistance ☐ Veteran's Benefits ☐ No Income, Supported by others

☐ Self Employed ☐ Unemployment ☐ Social Security ☐ No Income, Living off Savings

☐ Worker's Compensation ☐ Rental Property ☐ Pension ☐ Alimony/ Child Support

☐ Interest/CD's/ Stocks/ bonds ☐ Dividends/Royalties ☐ Other

For all checked please indicate:

Income Source	Gross Amount	How Often	Recipient	Start Date
1._____	$_____	☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Annually	☐ Applicant ☐ Spouse ☐ Household Member	___/___/___
2._____	$_____	☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Annually	☐ Applicant ☐ Spouse ☐ Household Member	___/___/___
3._____	$_____	☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Annually	☐ Applicant ☐ Spouse ☐ Household Member	___/___/___

SECTION IV: HEALTHCARE COVERAGE

Do you have other healthcare coverage? (Private Policy, HMO, Alliance, COBRA, IHS, VA, Tricare, other) ☐ Yes ☐ No

(Specify Type of Insurance Here)

Do you pay health insurance premiums? ☐ Yes ☐ No

If Yes to either, how much are the payments? $ _____ How often are the payments made? _____

If No to the above, is health insurance offered through your job/employer? ☐ Yes ☐ No

Do you wish to be considered for coverage of your COBRA or other insurance premiums? ☐ Yes ☐ No

If you have health insurance, send a copy of the front and back of your cards and complete below:

Health Insurance Company Name: _____ Effective Date on Policy: ____/____/____

Policy Number: _____ Group Number: _____

Medicaid

Have you applied? ☐ Yes ☐ No

If Yes, what was the outcome? ☐ Pending ☐ Approved- Medicaid#: _____ ☐ Spend-down (if applicable) - Amount: $ _____

☐ Denied– Reason: _____

Medicare

Do you have Medicare? ☐ Yes ☐ No

If Yes, what type(s)? ☐ A - Hospitalization ☐ B - Primary Care ☐ C - Medicare Advantage Plan ☐ D - Prescription Drug

Do you pay premiums for Medicare Part D? ☐ Yes ☐ No

Do you have "extra help" for Medicare Part D? ☐ Yes ☐ No

Applicants requesting assistance with premium deductibles or copays, please submit recent invoices.

Alternate Contact(s) and Signature

By signing this application, I authorize the Uninsured Care Programs to speak with the following person(s) about my application (i.e., social worker, case Manager ,family member):

Name	Organization	Relationship	Phone Number

Certification Statement

I certify that all the information in this application is true and correct and that I am a District of Columbia Resident. I understand the following: This information is being given in connection with the receipt of federal funds by the District of Columbia. Program officials will verify the information on this form. Program officials may periodically verify my Medicaid status and bill Medicaid as necessary. If I deliberately misrepresent information on this application, I may be required to repay benefits provided to me and I may be prosecuted under applicable State & Federal Statutes. I hereby apply for benefits under the Uninsured Care Programs and consent for my information to be used and disclosed as necessary for the purposes of my treatment, for payment of healthcare services, payment of healthcare premiums and for the healthcare operations of the Program.

Sign and Date this Form:

_____ _____

Signature of Applicant (or legal guardian if applicant is a minor) **Date**

SECTION V: HIV Information (To Be Completed by a Medical Professional)

PHYSICIAN INFORMATION and VERIFICATION (Please print or type) DEA # _____

Name _____ DC License # _____

Hospital or Facility _____ Medicaid # _____

Address _____ NPI # _____

City _____ State _____ Zip Code _____

Office Telephone Number (_____) _____ Ext. _____

DISEASE STAGING

1.) Is the applicant HIV infected? [ ] Yes [ ] No Year of First Positive Test _____

2.) What is this applicant's most recent CD4+ (T_4) count? _____/mm^3 Date of Test ___/___/___

3.) What is lowest CD4+ (T_4) count? _____/mm^3 Date of Test ___/___/___

4.) Viral Load (absolute value) _____ Date of Test ___/___/___

PLEASE ENCLOSE A COPY OF THE LAB (CD4+ and/or Viral Load) REPORT

5.) Is this applicant infected with Hepatitis C(HCV)? [ ] Yes [ ] No Date of Diagnosis ___/___/___

DISEASE HISTORY

1.) Does the applicant now have or ever had:

[ ] Malignancies [ ] AIDS Dementia/PML [ ] Mycobacterium Avium Complex

[ ] Wasting Syndrome [ ] Syphilis [ ] PCP

[ ] Hepatitis: [ ] A [ ] B [ ] C [ ] E

2.) Tuberculosis: [ ] No Evidence of TB [ ] Unknown

Evidence of TB **and**:	**or**	Evidence of TB **but**:
[ ] Active, receiving treatment		[ ] Inactive, prophylaxis
[ ] Active, no treatment		[ ] Inactive, no prophylaxis
[ ] Active, treatment unknown		[ ] Inactive, treated

3.) Has anti-retroviral treatment been recommended? [ ] Yes [ ] No

4.) Has PCP prophylaxis been recommended? [ ] Yes [ ] No

5.) Has the applicant had these immunizations:

Influenza	[ ] Yes	[ ] No
Hepatitis B Vaccine	[ ] Yes	[ ] No
Pneumonia	[ ] Yes	[ ] No

Physician Verification:

I verify that the information on this application is true to the best of my knowledge.

Physician Signature_____ _____

(MUST BE ACTUAL SIGNATURE) **(DATE)**

Please keep copies of all documents. Complete application in its entirety. Submission of an incomplete application will delay processing.