NEW YORK STATE DEPARTMENT OF HEALTH

AIDS INSTITUTE

APPLICATION INSTRUCTIONS FOR:

HIV UNINSURED CARE PROGRAMS

AIDS DRUG ASSISTANCE PROGRAM (ADAP)
ADAP PLUS (PRIMARY CARE)
HIV HOME CARE PROGRAM

1-800-542-2437

EMPIRE STATION
P.O. BOX 2052
ALBANY, NEW YORK 12220-0052

General Information

The N.Y.S. Department of Health's AIDS Institute offers three programs to provide access to health care (HIV Drugs, Primary Care, and Home Care) for New York State residents with HIV infection who are uninsured or underinsured. The three programs use the same application forms and enrollment process.

The **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. ADAP can help people with partial insurance or who have a Medicaid spenddown.

ADAP Plus (Primary Care) pays for primary care services at enrolled clinics, hospitals, laboratory providers and private doctors offices. The services include ambulatory care for medical evaluation, early intervention and ongoing treatment.

The **HIV Home Care Program** pays for home care services to chronically medically dependent individuals as ordered by their doctor. The program covers home health aide services, intravenous therapy administration and supplies and durable medical equipment. Services must be ordered through a home health care agency which is enrolled in the program.

HIV UNINSURED CARE PROGRAMS
CONFIDENTIALITY STATEMENT

Under New York State Law, HIV related information provided to the Programs is kept strictly confidential. Such information (i.e. that you are an ADAP participant) may be given to those parties necessary for the proper administration of the Program. These are individuals and organizations with whom the Programs need to discuss your application and/or participation in order to determine eligibility, pay for the service or drugs covered under the Programs, or properly account for the funds spent. Program staff is very aware of the participants' needs 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 not directly related to your application or participation in the Program.

- 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 card, 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 tell the Programs, in writing, 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).

These Programs are the payer of last resort and will contact your health insurance company or other third party reimburser (i.e. drug manufacturer rebate program) who will reimburse ADAP for drugs provided to you under the program. This is necessary for ADAP to recover funds which can then be used to expand the programs to cover new drugs/services and more people.

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 **1-800-542-2437**.

APPLICATION INSTRUCTIONS

Eligibility is based on financial and medical need. You need to provide documentation of residency, income and assets. A separate medical application must be submitted by your doctor.

Applications which are submitted with all required documentation are processed within two weeks. When you are approved you will get an Eligibility Card and instructions on how to use it. You must present this card and prescription at an enrolled pharmacy to receive covered medications at no charge. You show your card to participating Health Care Providers to receive covered medical services at no charge. You will receive Home Care services from an enrolled agency at no charge.

ALL INFORMATION PROVIDED TO THE PROGRAMS IS KEPT STRICTLY CONFIDENTIAL

(Please see the Confidentiality Statement on the previous page of this packet)

Name and Address

Please list your full name, social security number and date of birth. If there is another name you are known by please put that in the space provided and tell us which name you want on your card. Please make sure that you include your complete address. Incomplete information will delay receipt of both your card and vital Program information.

Proof of NYS residency is required. New York State Residency can be documented with a copy of **ONE** of the following (showing your name and address):

 Rent receipt Lease Drivers license Fuel/utility bill Voter registration card

Marital Status

Please check off whether you are married or single.

Race/Ethnicity/Language

Please check your race/ethnicity. If you do not speak English or if you have any other special language needs please let us know and we will try to meet them.

Health Insurance and Medicaid Information

Although the Programs cannot provide help to anyone who has the total cost of services or medication reimbursed by an insurance company, we can help to meet deductibles, co-payments or other out of pocket costs for people who have partial coverage or a waiting period. Please fill out both sections of the Health Insurance Information section of the application. If you have no insurance please check that box. If you have insurance coverage, you must send a copy of your benefits book. If you have concerns regarding you health insurance benefits you may indicate your concerns in writing to the Program. The Program will consider your concerns when determining your Program eligibility. If you have Medicaid please write your Medicaid number in the space provided. If you have a Medicaid spenddown amount please write what that monthly amount is. Services or drugs paid for by the Programs can be used to meet your spenddown amount.

Living Arrangement / Household Members

Please provide information regarding your household composition. The household may include persons legally responsible for you, such as a spouse, or parent if you are under 21. The household may also include individuals for whom you are legally responsible, such as a child under 21. Information about household members may help the program determine eligibility.

How did you find out about the Programs?

Please tell us how you found out about the Programs. This will help us with our outreach efforts.

Pharmacy Requests

If there is a pharmacy that you would like to use and they are not enrolled in ADAP we can contact them and see if they would like to enroll or we can refer you to an enrolled pharmacy.

Financial Eligibility
Financial eligibility is based upon a sliding scale of income and household size. Income for a household of one $44,000 per year; $59,200 for two and $74,400 for three or more.

Households cannot have liquid assets greater than $25,000. Liquid assets are cash, savings, stocks, bonds, etc. They do not include your car or home.

Please tell us if there are any other HIV infected people in the household, as this may assist in financial eligibility determination. This is optional; you do not have to answer this question.

Employment Status
Please tell us if you are employed full or part time or if you are medically disabled.

Income
Please provide complete income documentation for each member of your household. Include income only for household members with whom you have a legally responsible relationship (for example, spouse or child but not uncle or cousin). Financial eligibility is based on the gross income of the household. Gross income is income before deductions for income tax, employee's social security taxes, etc. Please tell us how often you receive income: weekly, monthly or annually.

For wage earners, income may be documented by copies of pay stubs for the previous 30 days. The pay stub must include the year-to-date salary, hours worked and the period the stub covers. If you cannot get a paystub, send us a notarized letter from your employer showing gross pay for the last 30 calendar days (this letter does not need to be written to the Programs, a "to whom it may concern" letter is enough) and a copy of the previous year's income tax return.

Individuals who are self-employed should provide business records for the three months prior to application, indicating type of business, gross income, net income, and the income tax return for the previous year. A notarized statement of current annual income must also be included.

Copies of unemployment checks, Social Security checks, pension checks, etc. should be sent as proof of other types of income.

Liquid Assets
People with liquid assets must send recent copies of statements showing the cash value and the amount of interest/dividends received. Pre-tax retirement savings will be counted as 50% of the cash value toward the $25,000 limit.

Alternate Contact Person
If you would like Program staff to contact someone other than yourself about your application, if we can not get in touch with you please list them here. Please read the confidentiality statement for information on our confidentiality policy.

Signature Required
Please sign and date the application. We cannot process an application that is not signed.

Problems or Information
If you are having problems filling out the application or would like to ask questions about the Programs please call toll-free at 1-800-542-2437.

Copy of the Application
If you would like a copy of this application returned to you when it is completed please check the line marked "Yes."