

**AIDS/HIV HEALTH INSURANCE PREMIUM SUBSIDY PROGRAM AND
DRUG ASSISTANCE PROGRAM APPLICATION/RECERTIFICATION INSTRUCTIONS**

Completion of Part A and Part B is voluntary however to determine eligibility for the Health Insurance Premium Subsidy and Drug Assistance Programs all information requested must be completed.

Personally identifiable information collected on the AIDS/HIV Health Insurance Premium Subsidy and Drug Assistance Program Application/Recertification will be used in determining a client's eligibility and may be shared with Department of Health and Family Services (DHFS) staff, client's pharmacy, physician, case manager, insurance company and employer if necessary.

The AIDS/HIV Program will maintain the confidentiality of all information contained on the Application/Recertification form. Disclosure of your Social Security number is optional and if provided may be used by pharmacists and/or insurance companies to identify clients' policies and records.

APPLICATION/RECERTIFICATION INSTRUCTIONS

Part A should be completed by the client and includes general information, financial and insurance coverage information. Part B must be completed by the physician and includes the client's information, confirmation of HIV infection and employment status. Both Part A and Part B must be completed and submitted to the AIDS/HIV Program.

Be sure to provide all of the information requested in each section. If the question does not apply, draw a line through the space provided for the answer.

PART A

SECTION I. GENERAL INFORMATION

The General Information section must be filled out completely. Be sure to provide your:

- ◆ Name
- ◆ 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.)
- ◆ Street Address and Mailing Address
- ◆ Home and/or Work Telephone number
- ◆ Gender
- ◆ Martial Status
- ◆ Veteran Status
- ◆ Race
- ◆ Ethnicity
- ◆ Preferred Language
- ◆ Wisconsin Residency (see attached Residency documentation)
- ◆ Case Manager, Agency Name and Telephone number
- ◆ Employment Status

- ◆ Physician Information - Provide the name, address and telephone number of the physician treating you for HIV infection. This should be the physician who will complete Part B.

- ◆ Pharmacy Information - Provide the name, address and telephone number of your pharmacy. AIDS/HIV Drug Assistance Program (ADAP) clients may choose any pharmacy provider as long as that pharmacy agrees to ADAP's billing and payment procedures. However, clients must choose one store location to provide their prescription(s) and can only switch if pre-authorized by the ADAP. Only authorized pharmacies will be reimbursed for approved prescription(s).

SECTION II. FINANCIAL INFORMATION

This section applies to you, your parent(s) if you are a minor, and your spouse, if you are married. The information for each item requested should be completed for all applicable parties and entered on the appropriate line. Family Income should be determined according to the 2008 Income Guidelines, listed in the following table. Include yourself, your spouse, and your dependents under family size.

2008 INCOME GUIDELINES		
Family Size	Federal Poverty Guideline	300% Of Guideline
1	\$10,400	\$31,200
2	\$14,000	\$42,000
3	\$17,600	\$52,800
4	\$21,200	\$63,600
5	\$24,800	\$74,400
6	\$28,400	\$85,200
7	\$32,000	\$96,000
8	\$35,600	\$106,800

- ◆ If you are on an unpaid medical leave, enter \$0 for your gross wages and salary. Do not enter the normal salary you would have received before your unpaid leave.
- ◆ If you have quit working, enter only your post-employment income. Do not enter your salary from when you were working.
- ◆ If you are working reduced hours, enter the wages or salary you are paid for those hours.
- ◆ If you have applied for Social Security but have not yet received an award, enter "pending" in the space provided.
- ◆ If you have a spouse, you must enter his or her income.
- ◆ As proof of income, you must attach either a copy of your latest tax return, W-2 form, a copy of a recent pay stub or benefit stub. Please submit the documentation that most accurately reflects your current income. **Failure to include proof of income will delay or prevent your eligibility to these programs.**
- ◆ If you indicated that you have no income, describe your means of support in the space provided on page 2 of the Application/Recertification. **Failure to indicate some form of support will delay or prevent your eligibility to these programs.**
- ◆ If your income is between 201% and 300% of the federal poverty level, you will be required to cover 3% of your annual premium in the Insurance Subsidy Program. The annual policy premium is twelve times the first monthly premium that is due after your Application/Recertification is approved. For example, if your first monthly premium is \$250, then your annualized premium is \$3,000 therefore, your contribution is 3% of \$3,000, which equals \$90. After you submit this Application/Recertification, you will be sent an eligibility determination letter that will indicate whether or not you are required to make a premium contribution. This letter will specify your expected contribution amount and explain how to submit payment, if applicable.

SECTION III. INSURANCE COVERAGE INFORMATION

Check all boxes that describe your current health insurance status but at least one box must be checked. If you have no health insurance of any kind check that box. Answer the series of questions about any health insurance policy. If you do not know the answer to these questions, please contact a customer service representative at your insurance company or a personnel representative at your former employer for assistance.

AUTHORIZATION TO RELEASE INFORMATION/AUTHENTICITY STATEMENT

You, a legal guardian or Power of Attorney completing the Application/Recertification, must sign and date the Application/Recertification indicating that the Authorization Statement has been read in full and will be complied with.

ADAP APPROVAL OF APPLICATION/RECERTIFICATIONS

Written notification of Application/Recertification approval or denial will be mailed to the client's mailing address provided in the General Information Section, the pharmacy address provided in the Pharmacy Information Section and the physician address provided in the Physician Section. If eligible, interim approval will be granted upon receipt of your completed Part A. If the part B from the physician is not received within four weeks of the interim approval date, authorization for prescription reimbursement under the ADAP will be suspended.

AIDS/HIV HEALTH INSURANCE PREMIUM SUBSIDY PROGRAM APPROVAL OF APPLICATION/RECERTIFICATIONS

An Application/Recertification for the subsidy program will not receive final approval until both parts A and B have been submitted and approved. Once a completed Application/Recertification is approved, the AIDS/HIV Program will arrange to pay for client's health insurance premiums. Written notification of Application/Recertification approval or denial will be mailed to the client's mailing address provided in the General Information Section. IF A PREMIUM IS DUE BEFORE YOU RECEIVE WRITTEN NOTICE THAT YOUR APPLICATION/RECERTIFICATION HAS BEEN APPROVED, YOU ARE RESPONSIBLE FOR THE PREMIUM PAYMENT. FAILURE TO PAY PREMIUMS ON TIME MAY RESULT IN LOSS OF YOUR INSURANCE COVERAGE.

ASSISTANCE IN COMPLETING THE APPLICATION/RECERTIFICATION

If you have questions about the information requested in this Application/Recertification call the AIDS/HIV Program at 1-800-991-5532. For assistance in completing this Application/Recertification you may also contact an AIDS/HIV case manager at one of the following organizations in your area:

WISCONSIN AIDS SERVICE ORGANIZATIONS AND COMMUNITY-BASED ORGANIZATIONS		
City	Agency	Phone Number
Beloit	AIDS Network	(608) 364-4027
Eau Claire	AIDS Resource Center of Wisconsin (ARCW)	(800) 750-2437
Green Bay	AIDS Resource Center of Wisconsin (ARCW)	(800) 675-9400
Janesville	AIDS Network	(608) 756-3010
Kenosha	AIDS Resource Center of Wisconsin (ARCW)	(800) 924-6601
La Crosse	AIDS Resource Center of Wisconsin (ARCW)	(800) 947-3353
Madison	AIDS Network	(800) 486-6276
Milwaukee	AIDS Resource Center of Wisconsin (ARCW) Healthcare for the Homeless of Milwaukee Milwaukee Health Services Sixteenth Street Community Health Center United Migrant Opportunity Services	(800) 359-9272 (414) 374-2400 (414) 267-3700 (414) 672-1353 (414) 389-6500
Superior	AIDS Resource Center of Wisconsin (ARCW)	(877) 242-0282
Wausau/Schofield	AIDS Resource Center of Wisconsin (ARCW)	(800) 551-3311

Return the completed Application/Recertification and income verification in an envelope marked "**CONFIDENTIAL**" to:

Division of Public Health
ATTN: Drug Assistance and Health Insurance Premium Subsidy Programs
P.O. Box 2659
Madison, WI 53701-2659

Or fax to 608-266-1288

Part B is to be completed by the client's primary physician and should be provided to him or her as soon as possible. Whenever possible, Part A and Part B should be mailed together.