HIV Drug Assistance Program and Insurance Assistance Program Application/Recertification – Part A

Assistance type	**Did someone help you with this application?**
☐ Drug assistance ☐ Insurance assistance	☐ Yes (please specify):_____ ☐ No

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 speak	**Language you read**
☐ English ☐ Spanish ☐ Other: _____	☐ English ☐ Spanish ☐ Other: _____

Address

Attach proof of address. Any document used to verify Wisconsin residency must be current, dated as described on the Acceptable Documents for Proof of Residency and Income document, and not expired. Proof must show the client's name and the client's current residential address. Residency documents with a P.O. Box are not acceptable. Proof must show a residential address in the state of Wisconsin.

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

Email	Best way to contact you: ☐ Mail ☐ 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.

Pregnancy status	**Veteran status**
☐ Pregnant ☐ Not pregnant or does not apply	☐ Veteran ☐ Not a veteran

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. All countable sources of income must be included when determining a client's income eligibility. Any document used to verify income must be current and dated as described on the Acceptable Documents for Proof of Residency and Income document. Proof must show the client's name, spouse's name, or other applicable household member's name.

Employment (Current job status)	☐ Employed full-time ☐ Employed part-time ☐ Unemployed/retired

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.

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?

BadgerCare

☐ Yes
☐ No. If no, choose one:
- ☐ Going to apply when eligible
- ☐ Not eligible financially
- ☐ Not eligible for another reason
- ☐ Might be eligible but declining to apply*
- ☐ Eligible but declining to apply*

*If you are or may be eligible but are declining to apply, please explain your reason:

Medicare Advantage Plan (Part C) or Medicare Drug Coverage (Part D)

☐ Yes
☐ No. If no, choose one:
- ☐ Going to apply when eligible
- ☐ Medicare open enrollment is closed
- ☐ Not eligible
- ☐ Lost coverage
- ☐ Might be eligible but declining to apply*
- ☐ Eligible but declining to apply*

*If you are or may be eligible but are declining to apply, please explain your reason:

Low Income Subsidy or Extra Help for Medicare Part C/D

☐ Yes
☐ No. If no, choose one:
- ☐ Going to apply when eligible
- ☐ Not eligible financially
- ☐ Not eligible for another reason
- ☐ Might be eligible but declining to apply*
- ☐ Eligible but declining to apply*

*If you are or may be eligible but are declining to apply, please explain your reason:

Employer sponsored health insurance

☐ Yes
☐ No. If no, choose one:
- ☐ Going to apply when eligible
- ☐ Workplace insurance open enrollment closed
- ☐ No insurance available through work
- ☐ Not eligible for another reason
- ☐ Might be eligible but declining to apply*
- ☐ Eligible but declining to apply*
- ☐ Unemployed

*If you are or may be eligible but are declining to apply, please explain your reason:

Private or commercial insurance (ACA/ Marketplace)

☐ Yes
☐ No. If no, choose one:
- ☐ Going to apply when eligible
- ☐ ACA open enrollment is closed and/or not eligible for a Special Enrollment Period (SEP)
- ☐ Might be eligible but declining to apply
- ☐ Eligible but declining to apply*
- ☐ Not eligible for another reason*

*If you are or may be eligible but are declining to apply, please explain your reason:

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) - $400 per month limit after tax credits	☐ Medicare Part C (Medicare Advantage) with drug coverage - $125 per month limit
☐ Insurance through work	☐ Medicare Part D (Prescription)
☐ COBRA	☐ Medicaid Purchase Plan (MAPP)
☐ Dental Plan - $60 per month limit, individual only	☐ Medicaid (Medicaid, Title 19, MA)
☐ BadgerCare Standard Plan (BCSP)	

Insurance premium payment

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

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 will be denied.

There are multiple ways to submit your application materials. You can complete your application on our new HDAP Online Portal (HOP) or submit a paper copy.

Method	How to access
Online	HDAP Online Portal (HOP) - The HOP can be found at https://hdap.wi.gov/. First time users: To access the HOP, you will need to sign up for a MyWisconsin ID. To sign up for MyWisconsin ID you will need to visit the following website for directions: https://det.wi.gov/Pages/MyWisconsin_ID.aspx. Once you have followed the steps listed and created your account on MyWisconsin ID, you can access the HDAP online portal by going to the HOP link.
Paper	Mail: Division of Public Health, **Attn: HDAP,** PO Box 2659, Madison WI 53701
	Fax: 608-266-1288
	Email: DHSDPHHDAP@dhs.wisconsin.gov

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