GOVERNMENT OF THE DISTRICT OF COLUMBIA
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DEPARTMENT OF HEALTH
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Application & Instructions
AIDS Drug Assistance Program (ADAP)
Health Insurance Assistance Program

WE ARE WASHINGTON DC

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

899 North Capitol Street, NE
Washington, DC 20002
Phone: (202) 671-4815
Fax: (202) 673-4365

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 DC ADAP, 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) 671-4815.

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 seven business days. Incomplete applications will

not be processed and applications without supporting documentation will delay receipt of your enrollment approval letter and vital program information.

When you are approved, you will receive a welcome letter and ID card. You must present ID card 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 60 days)
- Property tax bill or statement
- Rent receipt (past 60 days)
- Pay stubs or bank statement with your name and address (past 60 days)
- Letter from another government agency addressed to applicant (past 60 days)
- Active (unexpired) homeowner's or renter's insurance policy
- DC Healthcare Alliance Proof of DC Residency form
- If homeless, please provide a statement from case manager on facility letterhead
- Zero Income Statement (past 60 days)

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 60 days. The paystub must show the year-to-date earnings, hours worked, all deductions and the dates covered by the paystub. If you cannot obtain a paystub, please submit a letter from your employer on company letter head indicating gross pay for the past 60 days along with a copy of your previous year's individual 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 the previous year's individual 1040 individual 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 previous year's individual 1040 income tax return.

All Other Income
Copies of SSD/SSI award letters, unemployment checks, Social Security checks, pension checks, etc. from the past 60 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 notarized letter from that friend or family member stating how they support you. If you are not receiving income from any source, please complete a "zero income statement" attesting to this. Provide a no income statement from case management or agency letterhead or complete the DOH ADAP zero income document.

IV. Health Coverage

Applicant must include a copy of the front and back of all other health coverage cards. And a copy of the most recent premium invoice if the applicant is electing for premium assistance.

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. An invoice from the past 30 days is required from the insurance company for all clients applying for premium assistance benefits. 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. Please provide a letter from employer including premium amount and billing information. Applicants with outstanding balances must reconcile their account prior to enrolling into the program.

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) 671-4815.

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) 671-4815 for assistance. All applications must be signed and dated in order to determine eligibility. Please retain a copy of all documentation for your record. Please note there must be individual documents for each eligibility requirement. Your application can now be submitted online at https://dcenroll.ramsellcorp.com Contact DCADAP for your registration code.

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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

SECTION I: APPLICANT INFORMATION

Last Name		**First**		**M.I.**	**Other Name(s):**	**Date of Birth** *MM/DD/YYYY*	/ /
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)

☐ Employed: 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 ☐ No Income

☐ Interest/CD's/ Stocks/ bonds ☐ Dividends/Royalties ☐ Other ☐ Alimony/ Child Support

For all checked please indicate:

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

SECTION IV: HEALTHCARE COVERAGE

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

Specify Type of Insurance Here _____

Do you wish to be considered for ADAP assistance in the following? ☐ COBRA ☐ Copay Assistance
☐ Private Insurance Premium Assistance ☐ Employer-based Premium Assistance ☐ Medicare Part D Premium Assistance

Do you require assistance with health insurance premiums? ☐ Yes ☐ No

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

If health insurance is offered through your employer, see section "IV. Health Coverage" of Application & Instructions

Please complete below and attach 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/Alliance No. _____
☐ 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 must submit recent invoices from the past 30 days.

Alternate Contact(s) and Signature

By signing this application, I authorize the DC ADAP 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 DC ADAP 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**

APPLICANT NAME: **DATE OF BIRTH:**

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 REPORT (CD4+ and Viral Load)

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, receiving treatment		☐ Inactive, prophylaxis
☐ Active, receiving treatment		☐ Inactive, prophylaxis

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.