

Application

to Receive Allowable Services for HIV/AIDS Patient Care Programs:

- AIDS Drug Assistance Program (ADAP)
- ADAP Premium Plus (Insurance Services)
- State Housing Opportunities for Persons with AIDS (HOPWA)
- Ryan White Part B Consortia and other HIV/AIDS and Hepatitis Programs

Part 1 Applicant Information

HIV positive is an eligibility requirement.

Check if you are HIV Positive: Yes No Unknown (Provide a copy of an HIV Laboratory Test which shows your HIV status.)

Name _____
First _____ M.I. _____ Last _____

Date of Birth / / | Male Female Transgender SSN _____
MM DD Year

Race _____ Ethnicity _____ Language Spoken _____

Are you a Veteran? Yes No Have you served in the armed forces? Yes No

Are you pregnant? Yes No Don't Know

Do you have a housing need? Yes No

Do you rent? Yes No Monthly Payment \$ _____

Do you own your own house? Yes No Monthly Payment \$ _____

When were you first diagnosed with HIV? _____ Mode of transmission _____

Part 2 Living Arrangements

Address where you currently live: _____
Street Address _____

City _____ State _____ Zip _____ County _____

Mailing address: (if different) _____
Street Address _____

City _____ State _____ Zip _____ County _____

Telephone: () - () - () -
Home Work Other Contact

Email: _____

How many adults live with you? _____ How many children live with you? _____ (under 18 years of age)

Check how you prefer staff to contact you:

Home Phone Work Phone Other Contact Phone Employment Phone Mail Other _____

Part 3 Medicaid Insurance and Other Programs

Do you have an existing health insurance policy? Yes No
If Yes, provide name of insurance company _____

If NO, does your employer offer health insurance as a benefit? Yes No

Are you taking a prescription drug(s)? Yes No
If Yes, please list: _____

PLEASE READ THE FOLLOWING BEFORE YOU COMPLETE PART 4

Please check if you are participating in one of the following programs and bring the award or eligibility letter or card as proof:

- Medicaid Medicare Project AIDS Care (PAC) Food Stamps
- Temporary Assistance for Need Families (TANF) Women, Infants and Children (WIC)
- Name Other: _____

If you have a case manager, please provide his or her name: _____

SKIP PART 4 IF YOU HAVE PROOF OF ELIGIBILITY FOR ONE OF THE ABOVE PROGRAMS.

Part 4

Household Monthly Income

Household Income means gross income from all sources received by the applicant and the applicant's spouse (if married).

Household Monthly Income Before Taxes and Deductions
(Gross Income)

Name (First & Last)	Relationship of person to you	Monthly Work Income	Monthly Social Security	Monthly SSI Retirement Income	Unemployment, Child Support, Public Assistance, Other	Monthly Totals	Check if No Income*
	Applicant	\$	\$	\$	\$	\$	<input type="checkbox"/>
		\$	\$	\$	\$	\$	<input type="checkbox"/>
		\$	\$	\$	\$	\$	<input type="checkbox"/>
		\$	\$	\$	\$	\$	<input type="checkbox"/>
		\$	\$	\$	\$	\$	<input type="checkbox"/>
Total Monthly Household Income						\$	

*If you checked NO INCOME provide a statement as to how food, clothing and shelter are being provided to you.

Do you have a checking account? Yes No If yes, what is your current balance? _____

Name of employer(s): _____

Are you self employed? Yes No If yes, what type of business? _____

Business Street Address _____

City _____ State _____ Zip _____ County _____

Part 5

Rights & Responsibilities
(initial each item shown)

- _____ I understand that I am responsible for giving truthful and correct information on this application to the best of my knowledge. Failure to be truthful may prevent or delay a determination of eligibility to receive services.
- _____ I understand if I knowingly give information that is not true or withhold information and receive services that I am not eligible to receive, I may be lawfully punished and have to reimburse the Department of Health for services.
- _____ I understand the information I provide may be verified, which may include computer matching and the information I give about my income may be checked.
- _____ I understand that the information will be kept confidential in accordance with Florida and Federal law.
- _____ I understand not all services I am eligible to receive may be available, accessible or funded, and I may not meet specific program qualifications for some programs.
- _____ I understand that at any time during the application process, I can be denied eligibility if my actions are uncooperative, disruptive of office procedures, threatening or hostile toward staff.
- _____ I understand that the Department of Health eligibility staff cannot discriminate because of race, color, sex, age, disability, religion, nationality or political beliefs.
- _____ I understand I have the right to ask for a fair hearing if I think the decision of my ineligibility was unfair or incorrect.

Client Signature: _____ Date _____

For Eligibility Staff Only

Walk-in Mail Other _____

Date of appointment _____ Eligibility Staff: _____

Date determined eligible: _____

Date determined ineligible: _____ Date supervisory review: _____

Fair hearing information was provided: Yes No