

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

- AIDS Drug Assistance Program (ADAP)
- AIDS Insurance Continuation Program (AICP)
- State Housing Opportunities for Persons with AIDS (HOPWA)
- Ryan White Title II Consortia and other Bureau HIV/AIDS Patient Care Programs

PART 1. Adult Applicant Information: HIV positive is an eligibility requirement. Check if you are HIV Positive.
__Y__ __N__ __Unknown__. Provide a copy of an HIV Laboratory Test which shows your HIV status.

Name: _____
Male____ Female____ Transgender____
First M.I. Last Date of Birth (MM/DD/Year)
Race_____ Language_____

Check if you receive HIV/AIDS services from any of the following program(s):

ADAP__ AICP__ HOPWA__ TITLE II____ TITLE I ____ COUNTY HEALTH DEPARTMENT____ Other_____

If you have a Case Manager, please provide the name & agency: _____

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__ **Do you own your house?** Yes__ No__

How much is your monthly mortgage \$_____ or rent \$_____

Are you taking a prescription drug(s)? Yes__ No__ If you can, please name or bring your prescriptions to your appointment

PART 2. Living Arrangements

Address Where You Currently Live: _____
Number Street Apt. Number
City State Zip County

Mailing Address: _____
(if different) Number Street Apt. Number
City State Zip County

Home Telephone: _____ Other Contact Telephone: _____

Work Telephone: _____ Name of Employer(s): _____

Email: _____

How many adults live with you? ____ (Spouse/Parents/Adult Children/Partner/Roommate, etc.)

How many children live with you? ____ (Under 18 years of age)

Check how you prefer staff contact you:

HOME PHONE____ WORK PHONE____ OTHER CONTACT PHONE____ EMPLOYMENT PHONE____ MAIL____ OTHER____

PART 3. Medicaid Insurance and Other Programs:

Check if you receive services from the following programs:

Medicaid __ Medicare __ Project AIDS Care __ Veterans Administration _____ Children's Medical Services (CMS) ____
Other ____ (Name)_____

Are you currently receiving HIV/AIDS services from another local, state or federal public assistance program?

Yes__ No__ If yes, which one(s): _____

Do you have an existing health insurance policy? Yes __ No__ **If Yes, is it through an employer?** Yes __ No__

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

READ THE FOLLOWING BEFORE YOU COMPLETE PART 4 & 5

PLEASE CHECK 4 IF YOU ARE PARTICIPATING IN ONE OF THE FOLLOWING PROGRAMS AND BRING THE AWARD OR ELIGIBILITY LETTER OR CARD AS PROOF.

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

SKIP PARTS 4 & 5 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). This includes other adult persons living in the home, if they have joint financial arrangements with the applicant, such as banking (checking and savings) accounts, mortgage agreements, business or other personal finances. **DO NOT INCLUDE**, adults in the home with separate finances, live-in aides or persons under 16 years of age.

HOUSEHOLD MONTHLY INCOME BEFORE TAXES AND DEDUCTIONS

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						
Total Monthly Household Income						\$ _____	

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

PART 5. Cash and Items of Value

- Do you have a checking bank account? Yes ___ No ___ If yes, how much? \$ _____
- Do you have a savings bank account? Yes ___ No ___ If yes, how much? \$ _____ How many cars do you have? ____
- Do you have more than 1 home? Yes ___ No ___ Do you own property (other than your personal residence)? Yes ___ No ___
- Do you own a business? Yes ___ No ___ Name and Address: _____
- List other items of value such as Certificates of Deposits, Treasury Bills Other: _____

PART 6. Rights and Responsibilities (Please Initial by Each Item Below)

- I understand that I am responsible for giving truthful and correct information on this application and during the application process to the best of my knowledge and 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 pay the Department of Health back 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 towards staff.
- I understand 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 on my case was unfair or incorrect.

SIGNATURE REQUIRED _____ **Date** _____

FOR ELIGIBILITY STAFF ONLY

Date Stamped Receipt of Application: _____ Walk-In ___ Mail ___ Other _____
 Date of Appointment: _____ Eligibility Staff: _____
 Date Determined Eligible: _____ Date Referred to: Case Management ___ ADAP ___ AICP ___ HOPWA ___ Other: _____ Date _____
 Date Determined Ineligible: _____ Date Supervisory Review: _____ Fair Hearing Information Provided _____