NEW YORK STATE DEPARTMENT OF HEALTH
UNINSURED CARE PROGRAMS
Empire Station, PO BOX 2052
Albany, NY 12220

ADAP Plus Insurance Continuation (APIC) Application

The ADAP Plus Insurance Continuation (APIC) program is one of the services offered by the New York State Uninsured Care Programs. The purpose of the APIC program is to pay health insurance premiums on behalf of ADAP eligible participants.
If you have any questions about completing this application, please contact our hotline at 1-800-542-2437.

APIC PROGRAM REQUIREMENTS:

- If you are not enrolled with ADAP, you must fill out the Uninsured Care Programs (ADAP) Application. (Form DOH2794)
- You must meet all ADAP eligibility requirements: New York State residency, and certain medical, income, and asset criteria.
- You are paying for, or will need to pay for, your insurance premiums and cannot afford them.
- Your policy has full prescription drug coverage and outpatient care is among the covered benefits.

TYPES OF INSURANCE POLICIES COVERED:

- **COBRA -** COBRA is an extension of health insurance coverage through former employment, where the person pays the cost of the premium to continue coverage.
- **DIRECT PAY –** Insurance policy purchased directly from an Insurance Company.
- **MEDICARE PART D -** Insurance policy someone received by enrolling in a Medicare Prescription Drug Plan. For APIC to pay your Medicare Part D premium, your Plan must bill you directly rather than deduct the payment from your Social Security check.

Please review the entire application and fill out completely or processing will be delayed.

A. YOUR INFORMATION:	B. POLICY HOLDER INFORMATION (IF DIFFERENT):
Your Name:	Name:
ADAP ID Number (If Applicable):	Relationship:
Mailing Address:	Mailing Address:
Social Security Number: - -	Social Security Number: - -
Date of Birth: / /	Date of Birth: / /
Daytime Phone: ( ) -	Daytime Phone: ( ) -
Other Phone: ( ) -	Other Phone: ( ) -
Alternate Contact:	Relationship:
(Person to speak on your behalf - Family Member, Friend, Social Worker)	Phone: ( ) -

C. BACKGROUND INFORMATION:

Question		Details
1) Are you currently employed?	☐ Yes ☐ No	If yes, provide recent income information (e.g. current pay stubs) If no, provide supporting documentation (e.g. unemployment paperwork, current SSD award letter, or letter of support)
2) Are you currently getting Health Insurance through an employer?	☐ Yes ☐ No	If yes, is the employer contributing at least 50% of the premium? ☐ **Yes** (**Proof Required** – e.g. letter from employer) ☐ **No**
3) Is this a COBRA Policy?	☐ Yes ☐ No	If yes, you must send a copy of the COBRA paperwork which you received from the employer.
4) Is this a Direct Pay Policy? (Individual or Family)	☐ Yes ☐ No	If yes, you must include a copy of the most recent premium invoice showing amount currently due.
5) Is this a Medicare Part D Policy? (Prescription Drug Plan)	☐ Yes ☐ No	If yes, you must include a copy of your most recent premium invoice showing amount currently due.

D. INSURANCE COMPANY INFORMATION: *Please obtain and send a copy of the front and back of your insurance cards.*

Insurance Company Name:	Effective Date on Policy: / /
Address:	Policy Number:
	Group Number:
Member Services Contact (If Known):	Member Services Phone: ( ) -

E. PAYMENT INFORMATION: Payment Information Will Depend on Your Type of Insurance Plan.

- For COBRA, payment is often not made directly to the insurance company. Please contact your employer or COBRA administrator to determine where the payment should be sent (if the information is not on the COBRA letter). **Send us a copy of your COBRA paperwork.**
- For Direct Pay, **Send us the most recent invoice showing the current balance due.**
- For Payroll Deduction, information entered must be the employer's name, address, contact, and phone number for us to verify the insurance payment. **Send us a copy of the most recent pay stub.**

Company Name:	Contact Person:
Company Address:	Contact Phone: ( ) -
	Payment is Due: ☐ Monthly ☐ Quarterly
Company Federal Tax ID #:	☐ Other:
Payment Amount: $	Payment Due Date: / /

You May Need to Call Your Insurance Company to Complete the Following POLICY BENEFIT INFORMATION:

F. PRIMARY CARE COVERAGE Insurance Company Name:

Do you have co-payments for your Doctor or clinic visits?	☐ Yes ☐ No	If yes, what are they? If no, what is your benefit?	$ __________ Percentage: ______% Out of pocket expenses: $______ Lifetime Max: __________
Do you have an annual deductible?	☐ Yes ☐ No	If yes, what is it?	$ __________
Do you have out-of-network benefits?	☐ Yes ☐ No	If yes, what are they?	$ __________

G. PRESCRIPTION COVERAGE Name of Carrier:

Do you have co-payments for your prescription drugs at the retail pharmacy?	☐ Yes ☐ No	If yes, what are they?	Generic = $______ Preferred Brand = $______ Non-Preferred Brand = $______
Does your insurance company only cover a percentage of your prescription drug costs?	☐ Yes ☐ No	If yes, what percentage of costs is covered?	______%
Do you have an annual deductible?	☐ Yes ☐ No	If yes, what is it?	$__________
Are you able to get your prescribed medications by mail order? (3 month supply)	☐ Yes ☐ No	If yes, what are the co-payments:	Generic = $______ Preferred Brand = $______ Non-Preferred Brand = $______
If yes, are all drugs covered by your mail order?	☐ Yes ☐ No	If no, what is excluded?	__________
Does your Prescription Plan have an annual maximum (or cap) on your prescription coverage?	☐ Yes ☐ No	If yes, what is the amount? ☐ Annual Cap	$__________ ☐ Lifetime Cap

I certify that the above information is true and accurate to the best of my knowledge and I understand the following:

- This information is being given in connection with the receipt of federal funds by the State of New York.
- Program officials will verify the information on this form.
- If I deliberately misrepresent information on this application or the Uninsured Care Programs (ADAP) Application, I may be required to repay benefits provided to me and I may be prosecuted under applicable State & Federal Statutes.

I authorize the New York State Department of Health, Uninsured Care Programs, to obtain any information from the individuals or companies I have indicated on this form regarding my private health insurance coverage, including information regarding payee address, covered benefits and the status of my policy which will be used to determine if the Department will pay my Health Insurance Premiums.

I hereby apply for benefits under the Uninsured Care Programs 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: (If you are not the policy holder, both you and the policy holder need to sign and date this form.)

Signature of Applicant (or legal guardian if unable to sign) ______ Date ______ Signature of Policy Holder (if different than the applicant) ______ Date ______

Keep a copy of this form for your records and mail the original form and all documentation to:

Uninsured Care Programs, Empire Station, PO BOX 2052, Albany, NY 12220-0052

If you have questions or need more information please call us at 1-800-542-2437 between 8:00 AM and 5:00 PM Monday through Friday.