Application and Instructions for the Uninsured Care Programs

Medications (ADAP)
ADAP Plus (Primary Care)
Home Care Program
ADAP Plus Insurance Continuation (APIC)
Pre-Exposure Prophylaxis Assistance Program (PrEP-AP)

NEW YORK STATE DEPARTMENT OF HEALTH
AIDS Institute
Uninsured Care Programs
Empire Station, P.O. Box 2052
Albany, NY 12220
1-800-542-2437 or 1-844-682-4058

General Information

The NYS Department of Health, AIDS Institute offers five programs to provide access to health care (ADAP, Primary Care, Home Care, APIC and PrEP-AP) for New York State residents who are uninsured or underinsured. The Programs use the same application form and enrollment process, additional forms are required for Home Care and APIC.

ADAP pays for medications for the treatment of HIV/AIDS and opportunistic infections. ADAP can help people with no insurance, partial insurance, Medicaid Spend-down/Surplus or Medicare Part D.

ADAP Plus (Primary Care) pays for outpatient primary care services through participating clinics, hospitals, laboratory providers, and private practitioners.

The **Home Care Program** pays for home care services for chronically medically dependent individuals as ordered by their doctor. The program covers services through enrolled home health care agencies.

ADAP Plus Insurance Continuation (APIC) pays for cost effective health insurance premiums for eligible participants.

Pre-Exposure Prophylaxis Assistance Program (PrEP-AP) pays for outpatient services for eligible participants for the care and monitoring necessary to successfully use PrEP to prevent HIV infection.

Uninsured Care Programs Confidentiality Statement

Under New York State Law, HIV related information provided to the Uninsured Care Programs 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 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 card, with your name and ID number, is shown to 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 can tell the Programs, in writing, of someone you want the Programs to contact if Program staff cannot contact you for information (i.e. the social worker who is helping you apply for the program or a trusted friend or family member).

The Uninsured Care Programs are the payer of last resort and will contact your health insurance company or other third party payer who reimburse ADAP for drugs provided to you under the Programs. This is necessary for ADAP to recover funds which are used to expand the Programs to cover new drugs/services and more people.

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 drugs or services provided by the Programs. You may terminate your enrollment in the Programs in writing at any time.

A copy of the Programs' Privacy Statement can be found at: https://www.health.ny.gov/diseases/aids/general/resources/adap/

If you have questions, please call **1-800-542-2437** or **1-844-682-4058.**

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 and income is required. A separate medical application must be submitted by your clinician.

When you are approved, you will get an Eligibility Card and instructions on how to use it. You must present this card and prescription at a participating pharmacy to receive covered medications at no charge. Show your card to participating health care providers to receive covered medical services at no charge. If you need them, you will receive home care services from an enrolled home health care agency at no charge ($30,000 maximum life-time benefit).

A. 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 card. Please be sure the name you want on your card matches the name your clinician puts on your prescriptions.

Address
Proof of New York State residency is required. Residency can be documented with a copy of ONE of the following (showing your name and address). If you have a P.O. box where you receive your mail, you must include information documenting your physical address to document New York State residency.

- Pay stubs or bank statement with your name and address (within the past 90 days)
- Current Notice of Decision from Medicaid
- Fuel/utility bill (within the past 90 days)
- Phone bill (within the past 90 days)
- Rent receipt (within the past 90 days)

If you live with someone and have none of these items in your name, we need proof of their residency and a letter stating that you live with them.

Gender/Race/Ethnicity/Language
Please check your gender, race, ethnicity and language preference.

B. Health Care Coverage

The Programs can help people who have other health coverage and have difficulty paying for deductibles, co-payments, Medicaid spenddown/surplus or other out-of-pocket costs. Include a copy of the front and back of all other health coverage cards.

Medicaid
Indicate your Medicaid Status or whether you have applied for Medicaid. If you have a Medicaid spenddown/surplus write the amount in the space provided.

Medicare
Indicate if you have Medicare and if so, what type(s), A, B, C or D.

Health Insurance
Be sure to answer all questions regarding health insurance. If you are having trouble paying your health insurance premiums call **1-800-542-2437** or **1-844-682-4058** or complete the APIC application (form number DOH-2794c) which can be found at https://www.health.ny.gov/diseases/aids/general/resources/adap/

C. Income of Applicant and Household Members

Living Arrangement
Check the box that describes your 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.

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 excluding Medicare and Social Security withholding and the cost of health care coverage paid by the applicant.

Income Source
List all sources of income for you and all household members. This is income only for household members with whom you have a legally responsible relationship (for example, spouse or child, but not uncle, cousin or roommate). For each source, indicate the gross amount (before taxes), how often the income is received, and whether it is your income or a household member's. If any household member has no income, please indicate this in the income section. Proof of income is required. Provide complete income documentation for each source of the income listed. Types of income sources include: salary/wages (FT or PT), self-employment, unemployment, worker's compensation, public assistance, SSI (Supplemental Security Income), SSD (Social Security Disability), Social Security retirement, pension, veteran's benefits, alimony/child support, interest/dividends/royalties, rental property, other (specify), no income and living off savings.

For Wage Earners
Income should be documented by copies of pay stubs for the past 30 days. The pay stub must show the year-to-date earnings, hours worked, all deductions and the dates covered by the pay stub. If you cannot get a pay stub, send us a letter from your employer showing your gross annual pay and a copy of your most recent income tax return. (The letter does not need to be addressed to the Programs. A letter addressed "to whom it may concern" is enough).

Self-employed Individuals/Rental Income
Provide your most recent income tax return and a statement of projected current annual income.

All Other Income
Copies of current Social Security Disability/Supplemental Security Income award letters or checks, unemployment checks, pension checks, etc., should be sent as proof of other types of income.

No Income
If you have no income and are supported by a friend or family member, provide a letter from that friend or family member stating how they support you.

Living Off Savings
Send a copy of your savings account statement.

E. Alternate Contact(s)

For Program staff to talk to someone about your application, you must list them here. Please read the confidentiality statement that describes who we may contact regarding your application and enrollment.

F. Certification Statement and Signature

Carefully read the Certification Statement then sign and date the application. We cannot process an application that is not signed. Make a copy of the application and all documentation for your records.

Problems or Questions
If you have problems filing out the application or have questions about the Uninsured Care Programs or any required documentation, please call toll-free: **1-800-542-2437** or **1-844-682-4058** or review the "Frequently Asked Questions" document found at https://www.health.ny.gov/diseases/aids/general/resources/adap/

NEW YORK STATE DEPARTMENT OF HEALTH
Uninsured Care Programs
Empire Station, P.O. Box 2052
Albany, NY 12220
1-800-542-2437 or 1-844-682-4058

Application for the Uninsured Care Programs

This application is used to determine eligibility for the AIDS Drug Assistance Program (ADAP), ADAP Plus (primary care), HIV Home Care, ADAP Plus Insurance Continuation (APIC) and the Pre-Exposure Prophylaxis Assistance Program (PrEP-AP). Additional paperwork is needed for Homecare and ADAP Plus Insurance Continuation. If you have any questions about the programs or completing this application, contact our confidential hotline at **1-800-542-2437** or **1-844-682-4058.**

PLEASE COMPLETE THIS APPLICATION FULLY AND PRINT CLEARLY.

A. Applicant Information

Last Name _____ First Name _____ M.I._____

Other Name(s) Used _____

Date of Birth (Month/Day/Year) _____ Social Security Number _____

Address *Proof of residency is required.*

Street_____ Apt. No. _____

City_____ State_____ ZIP _____

Can program information be sent to the address listed? ☐ Yes ☐ No *If no, attach an explanation with an alternate address.*

Phone

Primary Phone (_____) _____ Secondary Phone (_____) _____

Can we leave a message? ☐ Yes ☐ No

Gender *Select all that apply:* ☐ Woman ☐ Man ☐ Transgender ☐ Gender Non-binary

Race ☐ White ☐ Black/African American ☐ Native American/Alaskan

Asian: ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian

Native Hawaiian/Pacific Islander: ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander

☐ More Than One Race ☐ Other _____

Ethnicity ☐ Non-Hispanic

Hispanic/Latino: ☐ Mexican, Mexican American, Chicano(a) ☐ Puerto Rican ☐ Cuban ☐ Other Hispanic/Latino(a) or Spanish Origin

Language Preference ☐ English ☐ Spanish ☐ Other _____

Do you require language assistance services? ☐ Yes ☐ No

Marital Status ☐ Single ☐ Married, Living Together with Spouse ☐ Married, Living Apart from Spouse

B. Health Care Coverage

Do you have other health care coverage? (Private Policy, HMO, Union, Retirement, Medicare or Other Health Plan) ☐ Yes ☐ No

If Medicare, what type(s)? ☐ A: Hospitalization ☐ B: Primary Care ☐ C: Medicare Advantage Plan ☐ D: Prescription Drug

Do you pay health insurance premiums? ☐ Yes ☐ No

If you have health insurance, send a copy of the front and back of your cards.
Call the program at 1-800-542-2437 or 1-844-682-4058 to find out how to get help paying your health insurance payments.

Medicaid

If you have Medicaid with a spenddown, enter spenddown amount $_____

If you were denied Medicaid, give the reason_____

C. Income of Applicant and Household Members *Proof of income is required.*

☐ Live Alone ☐ Live with Others ☐ Homeless/Shelter ☐ Corrections Release

List separately all income sources for applicant and all household members.

Household Member's Name*	Date of Birth	Relationship **Self**
Income Source	Gross Amount	How Often? ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Annually
Household Member's Name*	Date of Birth	Relationship
Income Source	Gross Amount	How Often? ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Annually
Household Member's Name*	Date of Birth	Relationship
Income Source	Gross Amount	How Often? ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Annually
Household Member's Name*	Date of Birth	Relationship
Income Source	Gross Amount	How Often? ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Annually

**If you would like us to speak with any listed household member, add their name as an alternate contact under Section D.*

D. Alternate Contact(s)

By signing this application, I authorize the Uninsured Care Programs to speak with the following person(s) about my application (i.e. social worker, case manager, family member):

Name	**Organization**	**Relationship**	**Phone**
_____	_____	_____	(_____)_____
_____	_____	_____	(_____)_____
_____	_____	_____	(_____)_____

E. Certification Statement and Signature

I certify that all the information in this application is true and correct and that I am a New York State resident. 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. 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 and federal statutes.

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 health insurance premiums and for the healthcare operations for the Program.

_____ _____

Signature of Applicant (or Legal Guardian If Applicant Is a Minor) Date

Keep a copy of this form for your records and mail the original form and all documentation to:
UNINSURED CARE PROGRAMS, EMPIRE STATION, P.O. BOX 2052, ALBANY, NY 12220-0052