

APPLICATION FOR HEALTH SERVICES INCLUDING DC ADAP, COBRA, MEDICAID EXPANSION, AND TICKET TO WORK

Administered by the District of Columbia Department of Health

Please FAX this application and all supporting material to:

(202) 673-4365

Note: After you have completed the application, please refer to this checklist to ensure that your application is complete. Your application will not be processed unless all of the required documents are attached.

- o Completed application forms (4 pages)
- o To be considered for any Medicaid related program, please provide one of the following:
 - Original birth certificate (case manager can provide signed attestation that he or she viewed original and submit a copy) OR
 - Submit a request for the District's Income Maintenance Administration to locate the original birth certificate
 - Certificate of Citizenship or Naturalization OR
 - Copy of a green card or other documentation that includes the A number
- o HIV status (only **one** of the following is necessary)
 - Doctor's signature (on p.4); or
 - Case manager's signature (on p.4).
- o Residency verification documents (only **one** of the following is necessary)
 - Copy of utility bill or a letter from a government agency with your DC address listed;
 - Voter registration card;
 - DC driver's license, or non-driver's identification; and/or
 - Lease or mortgage agreement.
 - If you are homeless, please have case manager provide support documentation on facility letterhead.
- o Income/Work Documentation (only **one** of the following is necessary)
 - Wages (at least one month of pay stubs or letter from employer stating hours worked and wages paid); or
 - Income (Social Security/public assistance/unemployment/Veteran's benefits/pension check stub or award letter).
- o Asset Documentation (all that are applicable) **Asset Limit is \$5,000**
 - Checking Account;
 - Savings Accounts;
 - Certificates of Deposit; Stocks/Bonds; or Mutual Funds/Trusts.
- o Insurance Information (if applicable), including Health Insurance/Medicare Part D card or letter from insurance company, proof of monthly premium, deductible, or co-payment amount(s) as needed
- o COBRA documentation (if applicable), including COBRA eligibility letter from employer, billing statement, and proof of up to three (3) months of paid premiums



APPLICATION FOR HEALTH SERVICES

- New Application
 Recertification

Administered by the District of Columbia Department of Health

For Office Use Only:
 Program _____
 Group _____
 Location Code _____

Section I: Basic Information

Last Name		First Name			Middle	
Social Security Number		Date of Birth		Phone		
Street Address		Apt #	City	State	Zip	Ward #
Mailing Address (if different)		Street	Apt #	City	State	Zip
Case Manager		Facility	Phone		Fax	

Please check the appropriate boxes for each question

Sex: Male Female Transgender

How many dependents are living with you? _____

Are you pregnant? Yes No

Race:

White Black/African American

American Indian, Eskimo, and Aleut

African Asian

Pacific Islander Multi-Racial

Native Hawaiian

How were you referred to DC ADAP?

- Doctor Friend
- Clinic Advertisement
- Case manager HIV Test Site
- Other (specify): _____

Ethnicity: Hispanic Non-Hispanic

Section II: Employment, Income, and Asset Information

Check if you work either:

- 40 or more hours per month
- 120 hours or more in the last three months

Note: *You must provide documentation of the hours worked (e.g., pay stubs, etc).*

Salary/wages \$ _____

Disability Benefits \$ _____

Public Assistance (GPA) \$ _____

Unemployment \$ _____

Pension \$ _____

Other: (please specify below) \$ _____

Total Monthly Income \$ _____

Checking Account \$ _____

Savings Account \$ _____

Other (Mutual funds,
CDs, Stocks/Bonds) \$ _____

Total Assets \$ _____

Name	Social Security Number	Date of Birth
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**APPLICATION FOR HEALTH SERVICES
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Section III: Medicaid, Medicare, Private Health Insurance Information

Have you applied for Medicaid within the last 6 months?
 Yes No

If yes, please check one:
 Pending Denied(Provide denial letter)
 Approved On Medicaid Spend-Down

If you are currently on Medicaid or Spend-Down, please provide:
 Medicaid #: _____
 Spend down amount \$ _____

Are you receiving any of the following benefits?
 TANF SSI SSDI

Medicare? Yes No
If yes, please provide a copy of Part D card

Are you receiving extra help with Medicare Part D costs? Yes No
If yes, please provide a copy of letter from Income Maintenance Administration

Are you seeking assistance with out-of-pocket costs? If yes, please check all that apply:

Premiums Co-Payments Deductibles

Do you have health insurance? Yes No

If yes, please provide a copy of your insurance card and the following information:

Health Insurance Company Address:

Contact Person: _____ Phone: _____

Have you met your prescription drug cap for the year?

Yes No

Do you wish to be considered for coverage of your COBRA premiums?

Yes No

(if yes, please provide a copy of insurance card along with supporting COBRA documentation)

Section IV: Clinical Information

Is the person named on this form HIV-infected?

Yes No

Physician's Name: _____

DC License Number: _____

Most recent viral load results _____
 Date _____

Most recent CD4 count _____
 Date _____

Please indicate if this person's CD4 count has ever been below 200.

Yes No

Is this person infected with Hepatitis C (HCV)?

Yes No

Please indicate the number of hospitalizations in the past year _____

Please list the person's current HIV drug regimen:

Is this person adherent to medications?

Yes No Don't know

Would they benefit from additional adherence support?

Yes No

Has there been a treatment interruption for this person?

Yes No

If yes, please indicate any known reasons for this treatment interruption:

- Incarceration Intolerant of Side effects
- Substance use Used other insurance
- Moved out of DC Mental health issues

Name	Social Security Number	Date of Birth
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CERTIFICATION STATEMENTS

Alternate Contact: I authorize DC MAA/HAA to speak with the following person or persons (e.g., relative, friend) about my application if you are not able to contact me. If at any time I wish to revoke this person's authorization, I will notify ADAP at (202) 671-4900.

Name	Phone Number	Relationship

Applicant Certification and Signature:

I certify that all of the information provided above is accurate and true. I authorize my healthcare provider to allow D.C. Medicaid and HIV/AIDS Administration officials access to (1) my healthcare records and other documents related to services rendered and (2) other pertinent medical information to the program for the purpose of determining my medical eligibility for programs and evaluation. Information may be shared between District agencies such as Medicaid, the Income Maintenance Administration, and the HIV/AIDS Administration in order to determine and process my eligibility for various programs.

I also understand and agree to the following:

- My participation is voluntary;
- Enrollment in the Medicaid Demonstrations are limited, and if the programs are already full at the time of my application I will be placed on a waiting list;
- If during the course of my enrollment in this program I become eligible for Title XIX or XXI (Medicaid/Healthy Families), I will be enrolled in the District Medicaid program in such a way that does not disrupt my continuity of care;
- DC MAA/HAA officials may contact my case manager to discuss information relevant to my application;
- DC MAA/HAA officials may verify the information on this form; and
- DC MAA/HAA officials may contact my insurance company to verify my coverage.

Further, I agree to inform the DC MAA/HAA office of any changes in my residency/address, income, Medicaid eligibility status and insurance coverage. Further, if I deliberately misrepresent information on my application, I may be required to repay benefits received under DC MAA/HAA, and I may be prosecuted under applicable District and federal law.

Applicant's Signature _____ Date _____

Name	Social Security Number	Date of Birth
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**APPLICATION FOR HEALTH SERVICES
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MEDICAL ELIGIBILITY FORM

Note: One of the following two boxes must be completed by the appropriate individual to serve as verification of the applicant's HIV status. Your application will not be processed if this form is not completed.

<i>Yes, the applicant named on this form is HIV-infected.</i>	
To Be Completed by Physician	
Name: _____	DC License Number: _____
Office Phone: _____	Office Fax: _____
<i>Physician's signature must be an original</i> _____	
<i>Date:</i> _____	

- OR -

<i>Yes, the applicant named on this form has previously been eligible for ADAP or other Ryan White-funded services.</i>	
To Be Completed by Case Manager	
Name: _____	Facility: _____
Office Phone: _____	Office Fax: _____
<i>Case Manager's signature must be an original</i> _____	
<i>Date:</i> _____	

**You may mail the application to:
ADAP/Department of Health
64 New York Avenue NE, Suite 5001
Washington, DC 20002-3326**