Rhode Island AIDS Drug Assistance Program
RECERTIFICATION
Enrollment Form

Do not write in this box →		Insurance

Instructions:

- You can enroll with a case manager at a RI Department of Health funded community-based organization to assist you with this application.
- Review *RI ADAP Client Agreement Statement*.
- Answer all of the questions on the *Financial Enrollment Form* (pages 1-3).
  Both you and your case manager (if you have one) must sign and date this form.
- Ask your medical doctor to complete and sign the *Medical Enrollment Form* (page 4).
- Submit both forms at the same time (*Financial and Medical*) along with proof of income and residency and copies of any health coverage/insurance cards.

Demographic Information

Last Name	First Name	MI
Street Address* (Mailing Address ~ *Must be RI address*)	**City**	**Zip**
Telephone ( ) _____-_____	**Social Security #** _____-_____-_____	

Contacting You

☐ Yes ☐ No Can we leave confidential message at this phone number?

Date of Birth ____ ____/____ ____/_____	Gender ☐ Male ☐ Female ☐ Transgender

Sexual Orientation

☐ Gay Man ☐ Lesbian ☐ Heterosexual ☐ Bisexual ☐ Other

Marital Status (Relationship Status)

☐ Married ☐ Domestic Partner ☐ Single/Never Married ☐ Divorced or Separated ☐ Widowed

*Remember to attach Proof of RI residency. This can include a copy of a driver's license, utility bill, or rental agreement. The address on the document should match the address above. If no permanent residence, your case manager can provide a letter documenting your current address.

Case Manager

Name		Organization
Address		City, State, Zip
Phone ( )	Fax ( )	E-Mail Address

Case Manager's Signature

_____ Date:_____

Additional Comments:

Return this completed form by mail or fax to:

Executive Office of Health & Human Services
Hazard building, Suite 60
74 West Road
Cranston, RI 02920

Tel: 401-462-3295
Fax: 401-462-3297
www.ohhs.ri.gov

Financial Information

Your gross annual income*	Dependents (including self)	Housing Status
$_____	_____(#)	☐ Permanent (rent or own) ☐ Temporary (shelter, family/friends, facility) ☐ Homeless
Total Liquid Assets**(see definition and exclusions below) $_____		

Employment

Are you currently employed? ☐ Yes ☐ No

*Gross income means total income before taxes and deductions. Your income includes all earnings and support, including SSDI, SSI, unemployment compensation, and other benefits, as well as, income from a legal spouse. Remember to attach proof of income, such as a copy of your most recent pay stub (showing period covered by the check), or a tax return or W-2 form for the most recent tax year. If self-employed, include a copy of your most recent federal tax return or 1099 form. If you have no earnings, please include a letter from your case manager stating that you have no income and describing how you are being supported.

**Liquid assets include any savings, checking, or money market accounts, stocks/bonds, investments, or other easily convertible assets EXCEPT for your primary residence and automobile.

Insurance/Health Care Coverage

Please indicate if you have or qualify for any of the following programs. If yes, provide your ID or Card # and/or name of insurer/carrier. If no, indicate if you have applied and when (if applicable).

Medicaid/Medical Assistance	☐ Yes ☐ No ID/Card#_____ ☐ Managed Care? ☐ HMO?	If no, have you applied? ☐ Yes ☐ No Date applied:_____
Medicare	☐ Yes ☐ No ID/Card#_____	If no, have you applied? ☐ Yes ☐ No Date applied:_____
Medicare Part D (Pharmacy Benefit)	☐ Yes ☐ No ID/Card#_____ Plan Name:	If no, have you applied? ☐ Yes ☐ No Date applied:_____
Rite Care	☐ Yes ☐ No ID/Card#_____	If no, have you applied? ☐ Yes ☐ No Date applied:
GPA	☐ Yes ☐ No ID/Card#_____	If no, have you applied? ☐ Yes ☐ No Date applied:
Private Insurance	☐ Yes ☐ No ID/Card#_____ Insurers Name:	Does your prescription benefits require you to use a mail order pharmacy? ☐ Yes ☐ No
Veterans Administration (VA)	☐ Yes ☐ No ID/Card#_____	If no, have you applied? ☐ Yes ☐ No Date applied:_____
Other Public Assistance (specify)_____	☐ Yes ☐ No ID/Card#_____	If no, have you applied? ☐ Yes ☐ No Date applied:_____

Is AIDS Project RI helping you with COBRA/Health Insurance payments? ☐ Yes ☐ No

*Remember to attach a copy of your insurance card for any of the programs above in which you participate. Insurance information and a copy of your card are REQUIRED for enrollment.

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Pharmacy

Store Name	Phone ( ) _____-_____	Do not write in this space ☐ Pharmacy contacted Date_____
Address		

*Pharmacy information is REQUIRED.

Would you be interested in participating in a Survey for ADAP ☐ Yes ☐ No Focus Group for ADAP? ☐ Yes ☐ No
If yes, which is the best way to contact you? (by phone please list phone number, by email please list email address)
Phone_____ email_____

Client Certification and Signature

I fully understand that by applying for this program, I am divulging personal information that will be used to assist the Rhode Island Department of Health in providing me with benefits associated with the RI AIDS Drug Assistance Program. I understand this information will be kept confidential, (§23-6-17 Confidentiality, §23-6-18 Protection of Records), but will be used by staff to review my eligibility for this program. Also, by signing this form, I understand that the information contained within may be used to verify HIV status, receive information from my physician about my care, or obtain other necessary information to provide me with these benefits. By applying for this program I fully understand that this does not mean that my application will be accepted, as funds are limited and eligibility requirements must be met. In addition, I understand Rhode Island Department of Health reserves the right to terminate benefits due to non-adherance to medication pick up, not recertifying every 6 months, a lack of funds and/or fraudulent claims on behalf of an applicant. I also understand that this program is a payer of last resort, meaning that I must exhaust all other possible sources of payment for these services before applying for this program. Lastly, I understand that it is my responsibility to provide Rhode Island Department of Health with truthful information and documentation about my financial, employment, insurance, and HIV status.

I certify that the information provided in this application is true and correct as of the date below and acknowledge that any intentional or negligent misrepresentation of the information may result in nullification of this application and liability for money granted.

1. **It is my responsibility to re-apply (recertify) with ADAP <u>every 6 months on or before my birth month and 6months following</u>. If I do not recertify, my ADAP benefits will be terminated.**

2. **It is my responsibility to pick up medications prescribed to me. I understand if I do not adhere to medication(s) prescribed, my ADAP benefits will be terminated.**

Lastly, I certify that I have received and agree to all the terms in the **RI ADAP Client Agreement Statement.**

Signature_____ Date_____

Print Name

Checklist

Please submit all required forms and documents at one time via fax or mail to the address at the bottom of the page. Incomplete applications will delay your enrollment and access to this program.

Did you remember to:

- ☐ Attach proof of Rhode Island residency? (copy of lease, utility bill with address, driver's license, etc.)?
- ☐ Attach proof of income (e.g., copy of pay stub, assistance checks)?
- ☐ Include a completed Medical Enrollment Form (next page) signed by your provider/physician?
- ☐ Attach copy (-ies) of any health insurance or benefits cards?
- ☐ Include your case manager's signature on page 1?
- ☐ Sign the client agreement above?

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Rhode Island AIDS Drug Assistance Program
MEDICAL Enrollment Form

Do not write in this box →	Client Code

Instructions

- **This form is to be completed by the client's Medical Provider.**
- **Please print clearly and provide all requested information.**
- **Sign form and return to client.**
- **Client – Return this form together with the Financial Enrollment Form and all required documentation.**

Client Name

Last First MI

Date of Birth

____/____/____
month day year

HIV
Approximate date of first positive HIV test:

Date
____/____/____
month day year

AIDS Diagnosis
☐ Yes ☐ No If yes, date of diagnosis:

Date
____/____/____
month day year

HCV Test
☐ Yes ☐ No If yes, date of test:

Date
____/____/____
month day year

HCV Diagnosis (if tested)
☐ Negative ☐ Positive

General HIV Medical Care Visit Previous 6 months
☐ Yes ☐ No
(please provide date for both Yes or No response)

Date of Last General HIV Medical Care Visit
Date of last test: ____/____/____
month day year

CD4 Count
Count:_____

Date of Last CD4 Test
____/____/____
month day year

NADIR Count
Count:_____

Date of NADIR
____/____/____
month day year

Viral Load (Most Recent)
Load:_____

Date of Last Viral Load Test
____/____/____
month day year

Test Type (bDNA, RT-PCR)

Drug Therapy: Have you ordered medications on the ADAP formulary for this client? ☐ Yes ☐ No
If Yes, which medication(s) were prescrtibed:_____

Has the patient committed his/her self to take medication(s)? ☐ Yes ☐ No

☐ No HAART medications ☐ ____(#) Antiretrovirals ☐ HCV Therapy

Name of Physician (print)_____ **RI Lic.#**_____

Clinic Name:_____

Signature of Physician_____**Date**____/____/____

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Rhode Island AIDS Drug Assistance Program
Client Agreement Statement

The following are guidelines that must be followed for you to receive drug coverage through the Rhode Island AIDS Drug Assistance Program (ADAP). The RI ADAP will keep your information strictly confidential §23 -6-17 Confidentiality, §23-6-18 Protection of Records). If you do not follow these guidelines, if you provide false information, or if we suspect you are using funds for ADAP to which you are not entitled, you may be terminated from RI ADAP.

By participating in ADAP, I agree to the following:

1. **I give permission to the RI ADAP staff (coordinator, program manager, eligibility technician, administrator) to contact:**
   a. My pharmacist
   b. My case manager
   c. My employer (for employee contributions to COBRA)
   d. My current or past health care provider(s)
   e. Any other person that I have specifically given permission to contact.

   If needed, RI ADAP may contact these people to maintain my participation in the program. RI ADAP staff may also contact any insurance companies (third party payers/administrators) to make sure I am covered and to answer any billing questions. RI ADAP may also contact any of the people in the above list when I leave the program, if necessary. This may be done to get information about my participation in the program.

2. **I give permission for my ADAP enrollment application files to be reviewed by the following:**
   a. HEALTH staff
   b. My case manager and/or health care provider
   c. Auditors or other individuals reviewing application files as required for program fiscal monitoring.

   Information in your ADAP enrollment application files will be kept strictly confidential. Under no circumstances will any personal identifying information in my ADAP file be shared with any unauthorized individual.

3. **I agree to notify HEALTH as soon as possible if any of this information changes. I need to report any other information that might change my eligibility for programs within 20 days of the change, including but not limited to:**
   a. Employment status
   b. Income
   c. Residence and Mailing address if separate
   d. Access to insurance coverage/Medicaid status
   e. Citizenship status

4. **My application may be rejected if I have provided false information.**

5. **ADAP cannot provide payments or reimbursements directly to me for any reason.**

6. **I may be required to pay back any ADAP benefits received if I was not eligible for them.**

7. **ADAP is not required to make retroactive payments for coverage before I was enrolled in the program or if my enrollment lapses.**

8. **It is my responsibility to re-apply (recertify) with ADAP <u>every 6 months on or before my birth month and 6 months following</u>. If I do not recertify, my ADAP benefits will be terminated.**

9. **It is my responsibility to pick up medications prescribed to me. I understand if I do not adhere to medication(s) prescribed, my ADAP benefits will be terminated.**