



## Family/ Dependent Information

List family members, including yourself whom live with you. This means your spouse or registered domestic partner (RDP) and family members under age 18.

Full legal name of family members	Date of birth (month/ day/year)	Relationship	Current ADAP client?	Does the person have income?
		SELF	-	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

## Resource

Resources: Tell us if you or anyone in your family (from the section above) has any of the resources listed below. You must check *Yes* or *No* for each resource. If you check *Yes*, give the total value.

Resource	Do you or your family have this resource?	Value
Cash, savings, or checking account	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Real Estate (include all residential properties)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Trust funds, annuity, or certificate of deposit	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Stocks or bonds	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Vehicles or recreational vehicles (not counting one vehicle for each licensed driver in the previous section above)	<input type="checkbox"/> Yes <input type="checkbox"/> No	

## Income

Please list the monthly gross income\* earned or received by you and your family members listed in the resources above.

Type of Income/ Benefit	Self	Spouse/ RDP	Dependents under 18	Required documentation
				For each type of income/ benefit received, please check which documents you are sending with this application.
<b>Work Income</b> (wages, tips, commissions, bonuses)	\$	\$	\$	<input type="checkbox"/> 2 months current, consecutive paystubs or earning statements for ALL jobs
<b>Self-Employment Income</b>	\$	\$	\$	<input type="checkbox"/> Most recent quarterly tax returns
<b>Stocks, bonds, interest income, cash dividends, trust or investment income</b>	\$	\$	\$	<input type="checkbox"/> Documentation from your financial institution showing income received and values, terms and conditions
Pension or Retirement Income (not social security)	\$	\$	\$	<input type="checkbox"/> Annual benefit statement
<b>Social Security Income</b> (SSI/ SSDI/ SSA)	\$	\$	\$	<input type="checkbox"/> Annual benefit statement
<b>Rental Income</b>	\$	\$	\$	<input type="checkbox"/> Award letter/ benefit statement
<b>Veterans Benefits</b>	\$	\$	\$	<input type="checkbox"/> Benefit award letter
<b>Unemployment Benefits / Worker's Compensation</b>	\$	\$	\$	<input type="checkbox"/> Compensation stubs or <input type="checkbox"/> Award letter

## Additional Income

<b>Alimony/ Child Support</b>	\$	\$	\$	<input type="checkbox"/> Benefit award letter <b>OR</b> <input type="checkbox"/> Other official documentation showing the amount received on a regular basis
<b>Public Assistance</b>	\$	\$	\$	<input type="checkbox"/> Award letter/ benefit statement
<b>Life Insurance / Disability</b>	\$	\$	\$	<input type="checkbox"/> Award letter/ benefit statement
<b>Other Income</b>	\$	\$	\$	<input type="checkbox"/> Signed and dated statement from person getting income. It must include gross income for last 2 calendar months and type of work

\*Gross income means total income before taxes and deductions. Your income includes all earnings and support, including SSDI, SSI, unemployment compensation and other benefits. Remember to attach proof of income, such as a copy of your most recent pay stub. If self-employed, include a copy of your most recent federal tax return or 1099 form. If you have no earnings, please include a client letter stating that you have no income and describing how you are being supported.

Do not write in this box.

Office use only →

Return this completed form by mail or fax to:

EOHHS, Hazard Building  
74 West Road, Suite 60  
Cranston, RI 02920

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

## Insurance/ Health Care Coverage

Please indicate whether your health care is paid for by 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).

<b>Medicaid/Medical Assistance</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	If no, have you applied? <input type="checkbox"/> Yes <input type="checkbox"/> No
	ID/ Card # _____	Date applied: _____
	<input type="checkbox"/> Managed Care? <input type="checkbox"/> HMO?	
<b>Medicare</b> (Please check: Part <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C)	<input type="checkbox"/> Yes <input type="checkbox"/> No	If no, have you applied? <input type="checkbox"/> Yes <input type="checkbox"/> No
	ID/ Card # _____	Date applied: _____
<b>Medicare Part D</b> (Pharmacy Benefit)	<input type="checkbox"/> Yes <input type="checkbox"/> No	If no, have you applied? <input type="checkbox"/> Yes <input type="checkbox"/> No
	ID/ Card # _____	Date applied: _____
	Plan Name: _____	
<b>Rite Care</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	If no, have you applied? <input type="checkbox"/> Yes <input type="checkbox"/> No
	ID/ Card # _____	Date applied: _____
<b>GPA</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	If no, have you applied? <input type="checkbox"/> Yes <input type="checkbox"/> No
	ID/ Card # _____	Date applied: _____
<b>Private Insurance</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	If no, have you applied? <input type="checkbox"/> Yes <input type="checkbox"/> No
	ID/ Card # _____	Date applied: _____
	Insurers Name: _____	
<b>Veterans Administration (VA)</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	If no, have you applied? <input type="checkbox"/> Yes <input type="checkbox"/> No
	ID/ Card # _____	Date applied: _____
<b>Other Public Assistance</b> (specify) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	If no, have you applied? <input type="checkbox"/> Yes <input type="checkbox"/> No
	ID/ Card # _____	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.**

## Pharmacy\*

<b>Store Name</b>	<b>Phone</b> ( ) _____ - _____	<b>Do not write in this space</b> <input type="checkbox"/> Pharmacy contacted Date: _____
Address		

**\*Pharmacy information is REQUIRED. Without it, we cannot contact the pharmacy and enroll you in the program.**

**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:** \_\_\_\_\_

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## 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-adherence 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 every 6 months on or before my birth month and 6 months following. 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? (Copy of both front and back of 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 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 every 6 months on or before my birth month and 6 months following. 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.**

**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

<b>Client Name</b>			<b>Date of Birth</b>		
Last	First	MI	____/____/____	____/____/____	____/____/____
			Month	Day	Year

<b>HIV</b>	<b>Date</b>
Approximate date of first positive HIV test:	____/____/____
	month day year

<b>AIDS Diagnosis</b>	<b>Date</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of diagnosis:	____/____/____
	month day year

<b>HCV Test</b>	<b>Date</b>	<b>HCV Diagnosis</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of test:	____/____/____	(if tested)
	month day year	<input type="checkbox"/> Negative
		<input type="checkbox"/> Positive

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

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

<b>CD4 Count</b>	<b>Date of Last CD4 Test</b>	<b>NADIR Count</b>	<b>Date of NADIR</b>
Count: _____	____/____/____	Count: _____	____/____/____
	month day year		month day year

<b>Viral Load (Most Recent)</b>	<b>Date of Last Viral Load Test</b>	<b>Test Type</b>
Load: _____	____/____/____	<input type="checkbox"/> bDNA
	month day year	<input type="checkbox"/> RT-PCR

**Drug Therapy: Have you ordered medications on the ADAP formulary for this client?**  Yes  No

If Yes, which medication(s) were prescribed: \_\_\_\_\_

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** \_\_\_\_/\_\_\_\_/\_\_\_\_

