Rhode Island AIDS Drug Assistance Program
Enrollment Form

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 the questions on the Enrollment Form (pages 1-5).
  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 5).
- 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

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
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<tbody>
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Street Address* (Mailing Address ~ Must be RI address)

<table>
<thead>
<tr>
<th>City</th>
<th>Zip Code</th>
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</thead>
<tbody>
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</table>

Telephone

(    )  _____ - ________

Social Security #

______ - ______ - ______

Contacting You

☐ Yes ☐ No Can we leave confidential messages at this phone number?
☐ Yes ☐ No Would you prefer that future recertification applications be sent to your case manager?

Gender

☐ Male ☐ Female ☐ Transgender

Date of Birth

___ ___ /___ ___ / ______

If applicable, Transgender Status

☐ Male-to-Female (MTF) ☐ Female-to-Male (FTM) ☐ Unknown

If female, Pregnancy Status

☐ Yes ☐ No ☐ Unknown

Sexual Orientation

☐ Gay Man ☐ Lesbian ☐ Heterosexual ☐ Bisexual ☐ Other

Marital Status (Relationship Status)

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

Ethnicity (please check one)

☐ Hispanic / Latino(a)
☐ Not Hispanic / Latino(a)

Race

☐ White ☐ Native Hawaiian/ Pacific Islander
☐ Black ☐ American Indian/ Alaska Native
☐ Asian ☐ More than one race

Preferred Spoken Language

Country of Birth

How did you contract HIV?

☐ Male to male sex ☐ Heterosexual sex ☐ Other
☐ IV drug use ☐ Do not know

*Remember to attach Proof of RI residency. If unable to provide proof of residency, please provide information of the person whom you are being supported by. 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.

**Please also include proof of identity. This can include a passport, photo ID, Visa, or any other viable documents even if expired.

Case Manager

Name

Organization

Address

City, State, Zip Code

Phone (    )  _____ - ________ Fax (    )  _____ - ________

Email Address:

Case Manager’s Signature

Date: _________________

Additional Comment:

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
**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.

<table>
<thead>
<tr>
<th>Full legal name of family members</th>
<th>Date of birth (month/ day/year)</th>
<th>Relationship</th>
<th>Current ADAP client?</th>
<th>Does the person have income?</th>
</tr>
</thead>
<tbody>
<tr>
<td>SELF</td>
<td>-</td>
<td>SELF</td>
<td>□ Yes  □ No</td>
<td>□ Yes  □ No</td>
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**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.

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

**Income**

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

<table>
<thead>
<tr>
<th>Type of Income/ Benefit</th>
<th>Self</th>
<th>Spouse/ RDP</th>
<th>Dependents under 18</th>
<th>Required documentation</th>
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</thead>
</table>

**Income**

Do not write in this box.

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

Rev. 11/27/2013

*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.**
<table>
<thead>
<tr>
<th>Program</th>
<th>Yes</th>
<th>No</th>
<th>ID/ Card #</th>
<th>Date applied</th>
<th>Managed Care?</th>
<th>HMO?</th>
<th>If no, have you applied?</th>
<th>Yes</th>
<th>No</th>
<th>Date applied</th>
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<td>Medicaid/Medical Assistance</td>
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<td>Medicare (Part A □ B □ C)</td>
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<td>Medicare Part D</td>
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<td>Private Insurance</td>
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<td>Veterans Administration (VA)</td>
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<td>Other Public Assistance (specify)</td>
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<td>Is AIDS Project RI helping you with COBRA/ Health Insurance payments?</td>
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*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**

<table>
<thead>
<tr>
<th>Store Name</th>
<th>Phone</th>
<th>Do not write in this space</th>
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<tr>
<td></td>
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<td>□ Pharmacy contacted</td>
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<td>Date: __________</td>
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*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: __________________________
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?
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

<table>
<thead>
<tr>
<th>Client Name</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last</td>
<td>First</td>
</tr>
</tbody>
</table>

**HIV**
Date
Approximate date of first positive HIV test: ____/_____/_____

**AIDS Diagnosis**
Date
☐ Yes ☐ No If yes, date of diagnosis: ____/_____/_____

**HCV Test**
Date
☐ Yes ☐ No If yes, date of test: ____/_____/_____

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

Date of Last General HIV Medical Care Visit
Date of last test: ____/_____/_____

**CD4 Count**
Date of Last CD4 Test
NADIR Count
Date of NADIR

**Viral Load (Most Recent)**
Date of Last Viral Load Test

**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

<table>
<thead>
<tr>
<th>Name of Physician (print)</th>
<th>RI Lic.#</th>
</tr>
</thead>
</table>

Signature of Physician ____________________________ Date _____/_____/_____

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Cranston, RI 02920
Tel: 401-462-3295
Fax: 401-462-3297
www.ohhs.ri.gov

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