

## 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)

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

Applications submitted with all required documentation are processed within two weeks. Incomplete applications and applications without supporting documentation will delay receipt of your enrollment card and vital program information.

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 435% 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. Proof of income is required. Provide complete income documentation for each source of the income listed. If any household member has no income, please indicate this in the income section. 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.

**D. Liquid Assets**

Households cannot have liquid assets greater than \$25,000. Liquid assets are cash, savings, stocks, bonds, etc. They do not include your car, home or federally-recognized retirement accounts (for example, IRAs, 401(k)s, 403(b)s, 414(h) contributions, etc.).

**Asset Source**

Check all sources of assets for you and all household members. This is 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 you check, indicate the current balance/value and whether it is your asset or a household member’s.

Proof of assets is required. People with liquid assets must send copies of the most recent statements (within 90 days) showing the cash value and the amount of interest/dividends received. Please make sure all statements include your name.

**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/>

## 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 healthcare coverage? (Private Policy, HMO, Union, Retirement, Medicare or Other Health Plan)  Yes  No

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.

<b>Household Member's Name*</b>	Date of Birth	Relationship <b>Self</b>
Income Source	Gross Amount	How Often? <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually
<b>Household Member's Name*</b>	Date of Birth	Relationship
Income Source	Gross Amount	How Often? <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually
<b>Household Member's Name*</b>	Date of Birth	Relationship
Income Source	Gross Amount	How Often? <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually

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

**D. Liquid Assets** *Proof of liquid assets is required.*

**Asset Source**  Checking Account  Savings Account  CDs  Stocks/Bonds/Mutual Funds  Annuities or Trusts  None  
**Balance/Value** \$ \_\_\_\_\_ **Recipient**  Applicant  Household Member  Joint

**Asset Source**  Checking Account  Savings Account  CDs  Stocks/Bonds/Mutual Funds  Annuities or Trusts  None  
**Balance/Value** \$ \_\_\_\_\_ **Recipient**  Applicant  Household Member  Joint

**E. 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
_____	_____	_____	( _____ ) _____
_____	_____	_____	( _____ ) _____

**F. 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**