NEW YORK STATE DEPARTMENT OF HEALTH
Division of Chronic Disease Prevention

Application for the Adult Cystic Fibrosis Assistance Program (ACFAP)

ACFAP requirements are that enrollees must :

- be 21 years of age or older;
- have a cystic fibrosis (CF) diagnosis;
- be ineligible for Medicaid;
- have been a resident of New York State for a minimum of twelve continuous months immediately prior to enrollment in the program;
- maintain health insurance; and
- contribute 7% of his/her and spouse's (if applicable) net income towards CF expenses.

PLEASE complete each item on the application form so that we can process your application promptly. Your answers to these questions will be kept completely confidential.

Section A Contact/Household Information

Full Name _____ (FIRST) _____ (MI) _____ (LAST) _____ (MAIDEN/OTHER NAME(S) (if applicable))

Home Address _____ (STREET) _____ (APT. #) _____ (CITY) _____ (STATE) _____ (ZIP)

Length of time at this address _____ (YEARS) _____ (MONTHS)

Mailing Address (If different from above) _____ (STREET) _____ (APT. #) _____ (CITY) _____ (STATE) _____ (ZIP)

Home Phone _____ Cell Phone _____

Email _____

Section B Personal Information

Sex ☐ Male ☐ Female

Date of Birth _____ Social Security Number _____

Marital Status ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If married, spouse's name _____

Section C CF Center Information

Do you receive care at a CF Center? ☐ Yes ☐ No If **yes**, answer the following:

Name of CF Center _____

Social Worker name _____ Phone number _____

Where did you hear about this program? ☐ CF Center ☐ Website ☐ Current enrolled program participant
☐ Other _____

Section D Health Insurance Policy Information

Do you currently have health insurance? ☐ Yes ☐ No

If no, you will need to obtain Health Insurance within 90 days if you wish to remain in the ACFAP.

Medicare

Do you have Medicare? ☐ Yes ☐ No If **yes**, what is your Medicare Claim #? _____

If **yes**, what type(s)? ☐ **Part A** (Hospitalization) ☐ **Part B** (Primary Care) ☐ **Part C** (Medicare Advantage Plan)

If you have Medicare **Part C**, do you pay a premium? ☐ Yes ☐ No

If yes, what is the premium amount? $ _____ ☐ Monthly ☐ Quarterly ☐ Annually

Plan Name _____

Do you pay premiums for Medicare **Part D** (Prescription Drug coverage)? ☐ Yes ☐ No

If yes, what is the premium amount? $ _____ ☐ Monthly ☐ Quarterly ☐ Annually

Plan Name _____

Do you pay premiums for Medicare Supplement Insurance (**Medigap**)? ☐ Yes ☐ No

If yes, what is the premium amount? $ _____ ☐ Monthly ☐ Quarterly ☐ Annually

Plan Name _____

Medicaid (MA)

Have you applied for Medicaid? ☐ Yes ☐ No If **yes**, date applied _____

If **yes**, what was the outcome? ☐ Pending ☐ Approved - Medicaid CIN# _____ Spend-down - Amount $ _____ (if applicable)

☐ Denied - Reason _____

Private Health Insurance

Primary Insurance Company _____ Member ID # _____

Policyholder full name _____ Relationship to you _____

This policy is provided through: ☐ Private Direct Purchase Insurance coverage ☐ Employer/Union Sponsored Insurance ☐ Other Group Insurance

This policy covers: ☐ Individual ☐ Individual and Spouse ☐ Family

Is this a COBRA plan? ☐ Yes ☐ No If **yes**, what is the end date of your COBRA coverage ? _____

Was this policy purchased from the NYS Health Plan Marketplace? ☐ Yes ☐ No

If **yes**, name of Tier: ☐ Bronze ☐ Silver ☐ Gold ☐ Platinum

Do you pay a premium for this insurance? ☐ Yes ☐ No

If **yes**, your cost $ _____ ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Quarterly ☐ Annually

Do you have prescription coverage? ☐ Yes ☐ No

Name of policy _____ Policy # _____
(If different from Primary Insurance)

Secondary Health Insurance - (Additional Insurance)

Secondary Insurance Company _____ Member ID # _____

Policyholder full name _____ Relationship to you _____

This **secondary policy** is provided through:

☐ Private Direct Purchase Insurance coverage ☐ Employer/Union Sponsored Insurance ☐ Other Group Insurance

This policy covers: ☐ Individual ☐ Individual and Spouse ☐ Family

Do you pay a premium for this insurance? ☐ Yes ☐ No

If **yes**, your cost $ _____ ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Quarterly ☐ Annually

Do you have prescription coverage? ☐ Yes ☐ No

Name of policy _____ Policy # _____
(If different from Primary Insurance)

Dental and/or Vision Insurance

DENTAL

Insurance Company _____ Member ID # _____

Do you pay a premium for this insurance? ☐ Yes ☐ No

If **yes**, your cost $ _____ ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Quarterly ☐ Annually

This policy covers: ☐ Individual ☐ Individual and Spouse ☐ Family

VISION

Insurance Company _____ Member ID # _____

Do you pay a premium for this insurance? ☐ Yes ☐ No

If **yes**, your cost $ _____ ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Quarterly ☐ Annually

This policy covers: ☐ Individual ☐ Individual and Spouse ☐ Family

Section E Employment and Income

If you are currently unemployed, please check the box(es) that best describes your current status:

☐ Permanent disability ☐ Temporary disability ☐ Homemaker ☐ Retired ☐ Student

☐ Other (specify) _____

Your income source (Check all that apply):

☐ Salary, wages, tips, and commissions, including overtime and training
☐ Veteran's benefits ☐ Rental income
☐ Social Security ☐ Alimony
☐ Child support ☐ Dividends or interest from stocks, bonds, savings, etc.
☐ Public assistance ☐ Unemployment benefits
☐ Self-employed ☐ Pensions/retirement ☐ Other income (specify) _____

Your spouse's income source, if applicable (Check all that apply):

☐ Salary, wages, tips, and commissions, including overtime and training
☐ Veteran's benefits ☐ Rental income
☐ Social Security ☐ Alimony
☐ Child support ☐ Dividends or interest from stocks, bonds, savings, etc.
☐ Public assistance ☐ Unemployment benefits
☐ Self-employed ☐ Pensions/retirement ☐ Other income (specify) _____

Section F Documentation Required with Application

Please submit proof as indicated below to verify each of the following:

Verification reqired for:	List of acceptable proof:
Residence – proof that you have continuously lived in New York State for the last 12 months	Enclose a copy of **TWO** or more of the following: A current statement and a statement issued 12 months prior to the date of application. • Lease • Mortgage agreement • Property tax bill • Rent receipts • School records • Voter's registration card • Statement from non-relative landlord • Medical statements
Date of Birth	Enclose a copy of **ONE** or more of the following: • NYS driver's license • Hospital records • Birth certificate • Adoption records • Baptismal certificate • Passport
Health, Dental and/or Vision Insurance Benefits	• Enclose a copy of the front and back of all insurance cards. • Please have a NYS-licensed medical provider submit a list of over-the-counter and prescription medications used for the treatment of your cystic fibrosis or any condition demonstrated to result from the progression or treatment of your cystic fibrosis.
If you do not have Health Insurance	Enclose a copy **IF IT APPLIES TO YOU:** • Medicaid denial letter
Income	Enclose copies of **ALL** of the following for both you and your spouse (if applicable): • **SIGNED** State/Local income tax return – most recent tax year • A copy of your most recent Federal tax return transcript. You can request a free copy of your Federal transcript from the Internal Revenue Service (IRS) by going to the IRS website: www.irs.gov or calling 1-800-908-9946 and following the prompts on the recorded message. • W-2's for all jobs and 1099's – most recent tax year

For proof of:	Enclose:
• Self-employment	business or income tax records
• Dividends or interest from stocks, bonds, savings, etc.	statements from financial institutions
• Social security benefits and/or additional income	1099 statement or check stub and include current year SS statement
• Rental income	receipt or copies of rent checks
• Unemployment Benefits	check stub or bank statement
• Child support payments you receive	cancelled check
• Alimony payments you receive	cancelled check
• Pensions/retirement income	annual statement or check stub
• Any other additional income	statement(s) or check stub(s)

Section G Voluntary authorization to discuss your ACFAP benefits

DOH is obligated by law to keep health and personal information confidential. State and federal law restricts its use and disclosure. See Attachment A for the ACFAP HIPAA Policy. Please read this carefully.

☐ Please check the box if you **do not** wish to assign an individual(s) authorization and ACFAP will only communicate with you directly.

ACFAP recognizes that there may be times you give permission for a family member or friend to speak on your behalf to the program about your ACFAP benefits. Please list the approved individual(s) to whom ACFAP staff may disclose your health care information, as necessary to process your ACFAP benefits.

I authorize:

NAME	RELATIONSHIP TO YOU	PHONE NUMBER
NAME	RELATIONSHIP TO YOU	PHONE NUMBER

to discuss my health and personal information including my income and health insurance with the NYS ACFAP staff to assist with my application and/or reimbursement for my CF related expenses.

By signing below, I acknowledge and understand that:

- This/these individual(s) is/are prohibited from dis-closing such information without my permission unless it is permitted by federal or state laws.
- Information may be transpired through phone, e-mail, fax and/or mail.
- The release may result in sharing of the information with others and DOH may not be able to control what happens to the information released pursuant to the authorization, and I will hold DOH harmless for such an occurrence.
- I have the right to revoke this authorization at any time by writing to the NYS ACFAP staff. If not previously revoked, this authorization will expire at the end of the NYS fiscal year or from one year from the date this form is signed, whichever comes first.

Your Signature _____ Date _____

Section H Healthcare Provider Certification

This Section must be signed by your Physician or Nurse Practitioner treating you for your cystic fibrosis.

An applicant applying for this program must have a confirmed diagnosis of Cystic Fibrosis.

A. APPLICANT INFORMATION (please print)

Full Name _____

Home Address _____
STREET

_____ _____ _____
CITY STATE ZIP

Date of Birth _____
MM/DD/YY

B. PHYSICIAN OR NURSE PRACTITIONER INFORMATION AND VERIFICATION (please print)

Name _____ NYS License # _____

Hospital or Facility _____

Address _____
STREET

_____ _____ _____
CITY STATE ZIP

Office Phone _____ _____
EXT

PHYSICIAN OR NURSE PRACTITIONER VERIFICATION

I verify that the above individual is currently under my care and has a diagnosis of Cystic Fibrosis.

Physician or Nurse Practitioner Signature _____ Date _____
MM/DD/YY

Please attach on your healthcare provider's letterhead, a current list of over-the-counter and prescription medications used for the treatment of this individual's cystic fibrosis or any condition demonstrated to result from the progression or treatment of his/her cystic fibrosis.

Return this completed application to:

Adult Cystic Fibrosis Assistance Program
New York State Department of Health
Riverview Center, Suite 350
150 Broadway
Menands, NY 12204

Phone: 518-408-5089 Fax: 518-408-7718
Email: acfap@health.ny.gov

Section I Applicant Attestation

Please sign and return the application along with the required documents indicated in Section G.

By submitting this application for assistance from ACFAP, I acknowledge the following:

- I am currently a New York State Resident and have been a resident of New York State for 12 months prior to applying to ACFAP.
- I am not receiving medical assistance pursuant to title eleven of article five of the social services law solely due to earned income (Medicaid).
- If enrolled in Medicare, I am required to enroll in a Medicare Part D drug plan, or I must have equivalent coverage through another plan. I understand that I must also maintain a Medicare Supplemental policy (Medigap) or Medicare Advantage policy unless equivalent coverage is provided by another plan. I understand that failure to provide identifying information necessary to enroll in a Medicare Part D plan may result in suspension and eventual termination of ACFAP coverage.
- If enrolled in a private insurance plan, I am required to purchase coverage that meets my cystic fibrosis care and treatment and includes the care and treatment of any other conditions resulting from cystic fibrosis.
- I consent to the exchange of information between ACFAP and the Internal Revenue Service (IRS), the Social Security Administration (SSA), the Medicare Program, the NYS Medicaid Program, the NYS Tax Department, private insurance companies, or any other entities, as necessary to verify my eligibility and/or to conduct ACFAP operations.

By signing below, I authorize my healthcare providers to release to ACFAP staff my medical information pertaining to services, products, prescriptions and/or diagnoses, to be used for payment, audit or related health care operations. I certify that the information I have provided in applying for payment under Article 27-G of the Public Health Law is complete and accurate to the best of my knowledge. I understand that ACFAP benefits could be denied if I knowingly and/or intentionally provide false information.

SIGNATURE OF APPLICANT OR LEGAL REPRESENTATIVE

Signature _____ Date _____
MM/DD/YY

Please note: If the above signature is a mark, a witness' signature is required below.

_____ _____
WITNESS PRINT NAME OF LEGAL REPRESENTATIVE (IF APPLICABLE)

What is your relationship to this individual? _____

Return this completed application to:

Adult Cystic Fibrosis Assistance Program
New York State Department of Health
Riverview Center, Suite 350
150 Broadway
Menands, NY 12204

Phone: 518-408-5089 Fax: 518-408-7718
Email: acfap@health.ny.gov

Program Received Date Stamp

ATTACHMENT A Notice of Adult Cystic Fibrosis Assistance Program Privacy Practices (ACFAP)

By law, the New York State Department of Health Adult Cystic Fibrosis Assistance Program (ACFAP) is required to protect the privacy of your personal health related information. ACFAP is also required to give you this notice to inform you how ACFAP may use and disclose (give out) your personal health related information held by ACFAP. We are also required to notify you should a breach cause a release of your information occur.

ACFAP must use and give out your personal health related information to provide information:

- To you or someone who has the legal right to act for you (your personal representative or caregiver),
- To the Secretary of the federal Department of Health and Human Services, if necessary, to make sure your privacy is protected, and
- Where required by law.

ACFAP has the right to use and give out your personal health related information to pay for your health care and to operate ACFAP, as permitted in your enrollment application. In exercising this right, ACFAP will restrict disclosure of your personal health related information to the minimum necessary to carry out ACFAP business purposes. For example:

- ACFAP may share your personal health related information with providers to make sure the providers are paid for the services they provide to you.
- ACFAP may use your personal health related information to make sure you and other ACFAP beneficiaries get quality health care, to provide customer services to you, or to resolve any complaints you have.

ACFAP may use or give out your personal health related information for the following purposes under limited circumstances:

- For public health activities (such as reporting disease outbreaks),
- For government healthcare oversight activities (such as fraud and abuse investigations),
- For judicial and administrative proceedings (such as in response to a court order),
- For law enforcement purposes (such as providing limited information to locate a missing person),
- For research studies that meet all privacy law requirements (such as research related to the prevention of disease or disability),
- To avoid a serious and imminent threat to health or safety,
- To contact you about new or changed benefits under ACFAP, and
- To create a collection of information that can no longer be traced back to you.

By law, ACFAP must have your written authorization to use or disclose your personal health related information for any purpose that is not included in this notice. You may revoke (take back) your written authorization at any time.

By law, you have the right to:

- See and get a copy of your personal health related information held by ACFAP for a reasonable fee.
- Have your personal health related information amended if you believe that it is wrong or if information is missing, and ACFAP agrees. If ACFAP disagrees, you may have a statement of your disagreement added to your personal health related information.
- Get a listing of those getting your personal health related information from ACFAP. The listing will not cover your personal health related information that was disclosed to you or your personal representative, was disclosed to pay for your healthcare, for ACFAP operations, or that was disclosed for law enforcement purposes.
- Ask ACFAP to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask ACFAP to limit how your personal health related information is used and disclosed to pay your claims and run ACFAP. Please note that ACFAP may not be able to grant (approve) your request.
- Get a separate paper copy of this notice.

If you believe ACFAP has violated your privacy rights set out in this notice, you may file a complaint with ACFAP by sending a written request to the following address:

Privacy Complaints
Adult Cystic Fibrosis Assistance Program
New York State Department of Health
Riverview Center
150 Broadway, Suite 350
Albany, NY 12204-0678

Phone #: 518-408-5089
Fax #: 518-408-7718
Email: acfap@health.ny.gov

You also may file a complaint with the Secretary of the Federal Department of Health and Human Services.

By law, ACFAP is required to follow the terms in this notice. ACFAP has the right to change the way your personal health related information is used and given out. If ACFAP makes any changes, you will get a new notice by mail within 60 days of the change.

The privacy practices in this notice will be effective April 14, 2003. Revised: September 2017