COLORADO
Department of Public Health & Environment

Colorado State Drug Assistance Program Application & Recertification Form

Please complete all of the information requested on this form. If approved, federal legislation requires the Colorado Department of Public Health and Environment (CDPHE) to review client eligibility twice each year.
If you don't know if you've been on ADAP before, call (303) 692-2716.

1. Full Legal Name (Last):	(First):	(Middle Initial):

2. What is your date of birth? _______/________/____________ (MM/DD/YYYY)	Name I Prefer to be Called:

3. A) Gender:
☐ Male ☐ Female ☐ Transgender, Male to Female ☐ Transgender, Female to Male
B) Gender at Birth
☐ Male ☐ Female

4. Ethnicity
☐ Non-Hispanic/Non-Latinx
☐ Hispanic/Latinx (please specify):
☐ Mexican ☐ Puerto Rican ☐ Cuban ☐ Other Hispanic/Latinx

5. Race (check all that apply):

☐ White
☐ Black
☐ Asian (please specify):
☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese
☐ Korean ☐ Vietnamese ☐ Other: ____________

☐ American Indian/Alaskan Native
☐ Native Hawaiian/ Pacific Islander (please specify):
☐ Native Hawaiian ☐ Guamanian
☐ Samoan ☐ Other: ___________

6. What is your Social Security Number (N/A if you do not have one)? __________-________-_____________

7. What is your relationship status?	☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Colorado Civil Union
8. What is your preferred language?	☐ English ☐ Spanish ☐ French ☐ Other __________________________

9. What is your current housing status:

☐ I live in permanent housing: ☐ Rent ☐ Own
☐ I am in an institution such as in hospice, a nursing home, jail, etc. Please Specify:________________

☐ I live in temporary housing (Staying with a friend, hotel, etc.)
☐ I am homeless

10. Street Address (PO Boxes will NOT be accepted)		May we contact you at this address? ☐ Y ☐ N	
City:	Colorado	ZIP Code:	County:
11. Mailing Address (if different than residential)		May we contact you at this address? ☐ Y ☐ N	
City:	Colorado	ZIP Code:	County:

Do you want to continue to receive paper applications*? ☐ Yes ☐ No

* You will need to create an account on COEnroll.com if you no longer want to receive paper applications. Please call the helpdesk at 303-692-2716 for information on how to register or if you would like to submit an electronic application or recertification now

12. What is your phone number?	May we leave a message?
Phone Number: ______________________ ☐ Home ☐ Cell Phone Number: ______________________ ☐ Home ☐ Cell	☐ Yes ☐ No ☐ Yes ☐ No

13. Email Address: ____

14. Would you like to receive Electronic reminders? ☐ Yes ☐ No If yes, how? ☐ Email ☐ Text Message

If you select yes you will NO longer received paper applications

15. Is there anyone that our staff may call if your mail is returned to us (or your number does not work)? ☐ Yes ☐ No

Name: ______________________ Phone Number: ______________________

Does this person know that you are HIV positive? ☐ Yes ☐ No

16. Do you have a case manager/social worker at an AIDS Service Organization or Medical Clinic? ☐ Yes ☐ No

If yes, list them below:

Name ______________________ Agency/ Clinic ______________________

Name ______________________ Agency/ Clinic ______________________

If you do not currently have one, would you like ADAP to make a referral to a case manager or social worker?

☐ Yes ☐ No

17. If you file taxes, what is your current tax filing status?	☐ Single ☐ Married ☐ Divorced ☐ Legally Separated

18. A) How many adults are in your household? _____ b) How many children are in your household? _____

19. If you do not file taxes, <u>What is the reason you don't file taxes?</u>

☐ I am not required to file (undocumented, make too little, etc.)

☐ I am claimed as a dependent on someone else's taxes.

☐ I am required to file, but don't. **REASON:**______________________

<u>MEDICAL INFORMATION</u>

20. When you were first diagnosed as HIV positive? Month_____ Year ______ (estimate if necessary)

Where were you diagnosed? ______________________ (please include city/state/country if applicable)

21. Have you <u>ever</u> been told by your doctor or a laboratory that you have AIDS? ☐ Yes ☐ No ☐ Not Sure

22. Have you <u>ever</u> been told that you have Hepatitis C? ☐ Yes ☐ No ☐ Not Sure ☐ Yes, but now cured.

23. What clinic are you currently receiving your HIV-related care?

HEALTH INSURANCE INFORMATION

24. Are you enrolled in Colorado Medicaid? (Check any that apply)

- ☐ Yes, I am enrolled
- ☐ I applied, but was denied. Reason: ________________
- ☐ No, I've never applied, If not, why? ________________
- ☐ I am still awaiting a decision
- ☐ I don't know my Medicaid Status
- ☐ I was enrolled but no longer qualify

25. Are you on Medicare? ☐ Yes (*if yes please fill in below*) ☐ No (*if no go to question 26*)

Medicare Number: (on your Medicare Card)____

What parts of Medicare are you enrolled in? ☐ PART A Effective Date ____/_____ ☐ PART B Effective Date ____/____

If you have Medicare, you must be enrolled in an employer pension plan, stand-alone Prescription Drug Plan (PDP) or Medicare Advantage plan with drug coverage (MA-PD) to participate in Bridging the Gap.
The program can pay the premium on your plan as long as you communicate changes in premium. Remember to submit your premium invoices annually (usually in January and anytime it changes) to avoid losing your Medicare drug coverage.

26. What is your employment status?

- ☐ Employed, working **MORE** than 32 hours a week (full-time)
- ☐ Employed, working **LESS** than 32 hours a week (part-time)
- ☐ Unemployed for more than 60 days
- ☐ Recently unemployed (less than 60 days)
- ☐ Self-employed
- ☐ Retired/Disabled
- ☐ Other: _____________________________________

27. If you are employed, did this employment start in the last 90 days?
☐ Yes ☐ No

28. Does your employer offer health insurance?

- ☐ Yes, I am enrolled
- ☐ Yes, but I have not enrolled. **REASON:** _____________________________
- ☐ My employer does not offer insurance coverage

If you or your spouse are employed and not currently enrolled in insurance *THROUGH YOUR EMPLOYER*, or on Medicaid or Medicare, you will need to have your employer complete the "Employer Insurance Information Form" on page 6 and attach it to your application form.
An ADAP staff member may reach out to you if they have additional questions.

29. Are you enrolled in insurance through Connect for Health, Colorado (ACA Marketplace)?
☐ Yes ☐ No ☐ I'm not sure

30. Are you enrolled in insurance that is NOT through the marketplace? (directly purchased from the insurance provider)
☐ Yes ☐ No ☐ I'm not sure

31. Please use the table below to provide your best estimate of your *GROSS* monthly income. You will need to attach proof of all income listed in this table (Unless you are enrolled in Medicaid), whether earned by you or another member of your household. See the instructions for the types of proof that ADAP will accept.

Include income from your legally married spouse and income earned by your children. Do NOT include other people living in your household. If you are under 18, please list your parent or legal guardian's income.

Use the table below to report any income you or your spouse receive
Include temporary and seasonal work and income from self-employment. If you have no household income ($0) from employment or from any other source, fill out "Statement of Support" on page 7.

Sources of income other than employment include:
Unemployment benefits, SSI, SSDI (Social Security Supplemental or Social Security Disability income), Veterans benefits, Short/Long-term disability, AND (Aid to the Needy Disabled), Retirement/Pension, SSI (Supplemental Security Income), TANF (Temporary Aid to Needy Families), Taxable trust income, Worker's compensation, Interest/Investment Income, or Alimony paid to you. Call the ADAP HelpDesk at (303) 692-2716 with questions.

Name of person receiving income (You, spouse, dependent, etc.)	Source Name (Employer Name, Social Security etc.)	Start date (or continuing)	Frequency of Pay *(Weekly, Bi-Weekly Etc.)*	Monthly Gross Amount *(estimate)*
				$
				$
				$

VERY IMPORTANT DATA SHARING UPDATE. Colorado ADAP has developed a system to share some of the information that you provide to ADAP with participating HIV service providers and case managers in order to simplify your process of recertification.** Please check one of the boxes below.

☐ **OPT IN**

- Your information* will be shared with your participating HIV service providers and case managers.
- Your information will be protected with a personal identification number.
- This will simplify your recertification in ADAP and other services.

OR

☐ **OPT OUT**

- Your information* will be not be shared.
- You will be required to submit recertification information to ADAP every six months **and to each of your Ryan White case managers and other HIV service and medical providers.**

Information* Shared Includes:

- ADAP Recertification Start and End Dates
- Income
- Health insurance status
- Housing
- Residential and mailing address
- Phone number
- CD4 and Viral Load

QUESTIONS?
Call the ADAP Help Desk
At (303) 692-2716

If you do not check one of the options below, you will be automatically opted in to data sharing.

You can call the ADAP Office at any time to opt out.

**You will be able to use your ADAP/Ramsell card to prove your eligibility at ANY Ryan White funded clinic or case management agency.

____________________ ____________________ __________
Applicant Name (Please Print) | Signature of Applicant or Parent/Guardian | Date

***You can opt in at any time by submitting a request in writing to the ADAP program. ***

ADAP Certification and Authorization of Release of Information

- I certify that the information provided in this application is complete and accurate, to the best of my knowledge.
- I understand that my failure to be accurate and complete may prevent or delay a determination of eligibility to receive assistance from ADAP.
- I understand that, for the purposes of determining my eligibility for ADAP, the CDPHE, its contractors and subcontractors may request further documentation to verify my HIV positive serostatus, my Colorado residency, and my financial, employment or insurance information as necessary.
- I authorize my prescribing physician, case manager, other departments and programs of the State of Colorado, and other information sources to release information necessary to complete the application process, to verify the accuracy of any information provided in this application, and to verify my ongoing eligibility for ADAP. I further authorize the CDPHE to utilize data from public health records to verify that I am living with HIV.
- I authorize the CDPHE to release information to my physicians, case manager, treatment centers, and other healthcare providers to facilitate provision of ADAP services.
- I understand and agree to submit periodic information regarding my continued eligibility for ADAP, including proof of income, proof of residency, health insurance coverage, and general updates on forms provided by the CDPHE. I understand that changes in my situation will be evaluated to determine my continued eligibility for ADAP. I will be notified in writing if I am to be discontinued from ADAP.
- I agree to notify, or have my case manager notify, the CDPHE of any circumstances affecting my participation in, or eligibility for, ADAP. I agree to notify the CDPHE within thirty (30) days if I change my address or other preferred contact information. I further authorize the CDPHE to contact the persons listed as "Emergency Contact" on this form if the CDPHE's attempts to contact me have been unsuccessful.
- I understand that I am to recertify for ADAP twice per year in a timely manner at my birth month and six months after my birth month.
- I understand that my ADAP eligibility will terminate if:
  - I do not cooperate with efforts to verify information in this application, or
  - I do not comply with the activities needed to identify/verify potential sources of alternative coverage, or
  - I fail to seek other forms of coverage, as instructed by the CDPHE, for which I may be eligible, or
  - The CDPHE becomes aware of material misrepresentation, withheld information, or documented fraud, or
  - Qualifying medication is no longer being prescribed to me.
- I understand that the CDPHE reserves the right at any time and without notice to modify the ADAP application form.
- I understand that my assistance through all CDPHE programs is contingent on state and federal funding. This funding is limited and may expire at any time without extended or alternative funds being available.
- I understand that completing this application does not ensure that I will qualify for this program.
- I understand that my name, address and any other personal identifying information provided in this application will be available to the CDPHE and its contractors and subcontractors, and that this information will not be disclosed to anyone else, except as required or permitted by law.
- I understand that I have a right to ask for a full hearing if I feel that a decision on my eligibility was unfair or incorrect of if I believe CDPHE staff or contractors discriminated against me based on my age, race, ethnicity, sex, gender identity, disability, religion, nationality, or sexual orientation.
- I understand that pursuant to the Colorado Governmental Immunity Act, C.R.S. § 24-10-101 et seq., the CDPHE is not liable for damages for any injury arising out of my participation in ADAP.
- I understand that I may revoke this authorization at any time in writing. However, the release shall remain valid until such time as I inform the ADAP, in writing, of my wish to terminate services through the program, or until such time as I no longer qualify for these services, whichever occurs first, except to the extent that action has been taken in reliance on this authorization.
- A copy of this authorization has the same effect as the original.

PLEASE REMEMBER TO NOTIFY ADAP IF ANYTHING IN THIS APPLICATION CHANGES

________________	________________________	________
Applicant Name (Please Print)	Signature of Applicant or Parent/Guardian	Date

Return this application to: CDPHE Care and Treatment Program
ADAP-3800, 4300 Cherry Creek Drive South, Denver, CO 80246
Fax: 303-691-7736 Phone: 303-692-2716

STATEMENT OF SUPPORT FOR ______________________ (NAME OF APPLICANT)

COMPLETE THIS FORM ONLY IF YOU CANNOT PROVIDE PROOF OF RESIDENCY IN YOUR NAME

OR IF YOU REPORT $0 HOUSEHOLD INCOME

SECTION 1 – IF **SOMEONE ELSE** PROVIDES YOU WITH SUPPORT, HAVE HIM/HER FILL OUT THIS PART OF THE FORM AND HAVE HIM/HER SIGN IN SECTION 3. **THIS PERSON MUST PROVIDE PROOF THAT THEY RESIDE AT THE ADDRESS LISTED.**

Name of person providing support:

____

What is your relationship to the applicant?

- ☐ Legally married in the State of Colorado
- ☐ Domestic partner/civil union/partner
- ☐ His/her parent (biological or adoptive)
- ☐ His/her child (biological or adoptive)
- ☐ Other relative (brother, sister, aunt, uncle, brother-in-law, mother-in-law, etc.)
- ☐ Other (friend, neighbor, etc.)

Type of support provided for free or minor charge (check all that apply):

- ☐ Lodging
- ☐ Food
- ☐ Telephone
- ☐ Other (describe): ___________________

For what part of the past 12 months did the applicant live in your household? _____________

On your most recent U.S. Tax Return, did you claim the applicant as a dependent?

- ☐ Yes
- ☐ No
- ☐ Have not filed a U.S. Tax Return

Please provide current contact information so we can contact you to verify any information.

Mailing Address:

____

____

Daytime Phone (____) ____ - ________

SECTION 2 – IF YOU HAVE $0 OF HOUSEHOLD INCOME AND ARE **NOT RECEIVING SUPPORT FROM ANY OTHER INDIVIDUAL**, COMPLETE THIS PART OF THE FORM AND SIGN IN SECTION 3.

Explain how you cover the costs of the following:

Housing/shelter _____________________________

Food _____________________________

Transportation _____________________________

Telephone _____________________________

Utilities _____________________________

Other
(Cigarettes, etc.____________________________

If you are living off of savings, please provide a bank statement or describe why such documentation is not available (for example, your savings is in the form of cash or a reloadable credit card):

____

____

____

SECTION 3 – LEGALLY BINDING SIGNATURE

By signing below, I assert that the contents of this form are complete and accurate, to the best of my knowledge. ***I acknowledge that intentional misrepresentations in this form may constitute an attempt to defraud the State of Colorado, which could result in severe criminal and civil penalties****. I authorize the State of Colorado to contact me and to conduct other research necessary to verify the accuracy of the statements made on this form.*

_______________________________	_______________________________	_____________
Support Provider Signature	Applicant Signature	Date

Employer Insurance Information Form

APPLICANT: This form is required if you or your spouse is employed and you have said that you are not eligible for or enrolled in health insurance. This may be because your employer does not offer health insurance, you are not eligible for specific reasons, or the insurance does not cover needed services. ***A copy of this form must be provided for every family member that is currently employed.***

EMPLOYER: Please complete this form, have an authorized representative sign it, and return the form to the employee. This information will need to be provided every six months.

EMPLOYEE NAME:
EMPLOYER (Business Name)

To be completed by the EMPLOYER:

1. Do you offer a health insurance plan to any of your employees? ☐ Yes ☐ No

   *If **NO**, skip to the signature portion of this form*

   *If **YES**, to whom was the health insurance offered, and was it accepted?*

Employee	☐ Not eligible ☐ Offered, but not accepted ☐ Offered and accepted	If not eligible, explain if this person could become eligible in the future, and when (e.g., becomes full time). Potential eligibility date: ___/____/_______
Spouse Name(s): ______________	☐ Not eligible ☐ Offered, but not accepted ☐ Offered and accepted	If not eligible, explain if this person could become eligible in the future, and when (e.g., employee becomes full time). Potential eligibility date: ___/____/_______
Dependent(s) Name(s): ______________ ______________	☐ Not eligible ☐ Offered, but not accepted ☐ Offered and accepted	If not eligible, explain if dependents could become eligible in the future, and when (e.g., employee becomes full time). Potential eligibility date: ___/____/_______

2. What is the date for your company's next open enrollment period? ____/_____/_____

   When does coverage begin after open enrollment? _____/______/______

COMMENTS: ____

➲ **Please attach a copy of your employee benefits summary or other plan information, if available.**

EMPLOYER REPRESENTATIVE COMPLETING THIS FORM:	**TITLE:**	**PHONE:**
EMPLOYER'S AUTHORIZED SIGNATURE		**DATE:**

EMPLOYER: Please return this form to the employee along with explanation of benefits

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