



Use this form to renew your enrollment with the Colorado AIDS Drug Assistance Program (ADAP), which includes Medication Assistance, Health Insurance Assistance, Supplemental Wrap Around, and Bridging the Gap, Colorado. Use this form even if your enrollment has expired. Please complete all of the information requested on this form. Federal legislation requires the Colorado Department of Public Health and Environment (CDPHE) to review client eligibility twice a year. This form is not optional. If you do not return this form, you may lose medication and/or insurance assistance from CDPHE and your regional AIDS Service Organization.

1. Full Legal Name (Last):	(First):	(MI):	Has this changed since your last recertification? Yes <input type="checkbox"/> No <input type="checkbox"/>
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2. What is your date of birth? \_\_\_\_/\_\_\_\_/\_\_\_\_ (MM/DD/YYYY)

3. Has your gender status changed since your last recertification? (transgender, male to female, etc.):  Y  N  
If yes, describe:

4. What is your current housing status?  
 I live in permanent housing: Rent  Own   
 I am in an institution (hospice, nursing home, **jail**, etc.)  
 I live in temporary housing (staying with a friend, hotel, etc.)  
 I am homeless

5. What is your current **residential** address?

Street Address (P.O. Boxes will <b>NOT</b> be accepted)		May we contact you at this address? <input type="checkbox"/> Y <input type="checkbox"/> N	
City	County	COLORADO	ZIP Code

**Not Enrolled in Medicaid?** – Attach proof of your residential address, such as a copy of your state ID. See the instructions for the types of proof accepted by ADAP. If you can't provide proof in your own name, fill out the Statement of Support found on page 6 and attach a proof of address for the person you live with, such as a copy of his/her state ID.  
**Enrolled in Medicaid?** – Medicaid will verify your address, so **no further documentation is needed.**

6. What is your current **mailing** address?

Street Address (P.O. Boxes will be accepted, but not outside Colorado)		May we contact you at this address? <input type="checkbox"/> Y <input type="checkbox"/> N	
City	County	COLORADO	ZIP Code

7. At what phone numbers can we reach you during **daytime** hours?

Phone Number ( )  Home  Work  Cell Phone  
 May we leave a message on this phone?  Y  N  
 Phone Number ( )  Home  Work  Cell Phone  
 May we leave a message on this phone?  Y  N

Do you have an email address that we may contact you at? (Please print clearly):  
 \_\_\_\_\_@\_\_\_\_\_.

8. Is there anyone that our staff may call if your mail is returned to us (or your phone number does not work)?  
 Y  N  
 Name: \_\_\_\_\_ Phone Number: ( ) \_\_\_\_\_  
 Does this person know that you are HIV positive?  Y  N

Due to new data requirements of the Health Resource Services Administration, Colorado ADAP needs to collect the additional information below. Once collected, we will not ask for the information again. **Please note: the federal government awards some funding based on the number of individuals in a jurisdiction that are of a minority status.**

9. What is your Ethnicity?  Hispanic/ Latino (a)  Non-Hispanic  Unknown  Prefer Not To Answer

**If** you answered that you are of Hispanic/Latino (a) ethnicity, how would you identify?

Check all that apply:

- Mexican, Mexican American, Chicano/a  Cuban  
 Puerto Rican  Another Hispanic, Latino/a or Spanish origin  
 Prefer Not to Answer/ Unknown  Unknown

10. Do you identify as being of Asian ancestry?  Yes  No

**If** you answered that you are of Asian ancestry, how would you identify?

- Asian Indian  Chinese  
 Filipino/a  Japanese  
 Korean  Vietnamese  
 Other Asian  Prefer Not to Answer /Unknown

11. Do you identify as being of Hawaiian or Pacific Islander ancestry?  Yes  No

**If** you answered that you are of Hawaiian or Pacific Islander ancestry, how would you identify?

- Native Hawaiian  Guamanian or Chamorro  Samoan  Other  
Pacific Islander  Prefer Not to Answer/ Unknown

12. Colorado ADAP is considering using optional text messaging to notify members of certain items. Would you be interested in receiving a text message reminder in the month that your ADAP recertification is due?

Yes  No

Would you be interested in receiving text message reminders about taking your medications if available?

Yes  No

Phone number to be used for texting: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

13. Do you also have a case manager/social worker at an AIDS Service Organization or Medical Clinic?  Y  N

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?

Y  N

14. What is your current relationship status?  Single  Married  Legally Separated  Divorced

Colorado Civil Union  Married to a same-sex partner in a state where the marriage is recognized

Other Describe: \_\_\_\_\_

*Please be aware that if you are married, your spouse and any dependents will be considered as part of your "household". Income earned by any member of the household will be considered in determining your eligibility for the Colorado AIDS Drug Assistance Program. You will need to provide verification of the income of all members of your household, not just your own.*

15. Household size

Did you file a tax return in the past 12 months?  Y  N

If **yes**, how many dependents did you claim on the return (Box 6d on Form 1040, or "1" if you filed Form EZ)? \_\_\_\_\_

If **no**, mark if any of the following are living in your household:

a spouse

your children (by birth, marriage, or legal adoption) under age 19 How many? \_\_\_\_\_

Are you being claimed as a dependent on someone else's tax return?  Y  N

Are any of your children claimed as dependents on someone else's tax return?  Y  N

16. If you are **female**, are you pregnant?  Y  N  Not Applicable

If yes, when are you due to deliver? \_\_\_\_\_ (Month)

17. What is your Social Security Number (if you have one?) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

18. What is the name of the doctor who currently writes your **HIV** medication prescriptions?

At what clinic or office do you get your HIV Care?

19. How do you fill your HIV medication prescriptions?

I pick them up at \_\_\_\_\_ pharmacy

I get them by mail from \_\_\_\_\_ pharmacy

My insurance makes me get them through a specialty pharmacy

(name): \_\_\_\_\_

Other

20. Have you been told by your doctor or a laboratory that you have AIDS?  Y  N  Not Sure

21. Have you been told that you have Hepatitis C?  Y  N  Not Sure

If yes, may a CDPHE staff case manager call to talk to you about support services related to Hepatitis C?  Y  N

**INSURANCE INFORMATION**

22. Are you currently enrolled in health coverage from **any** of the following:

Private Insurance  Employer based insurance  Medicaid  Medicare

I have lost my insurance/ I am not currently enrolled in an insurance

I am not eligible for any form of health insurance  My employer offers insurance, but I am **not** enrolled

I recently applied for \_\_\_\_\_, no answer yet

Comments:

**INCOME & EMPLOYMENT INFORMATION**

23. What is your current employment status?

- Employed by: \_\_\_\_\_ and working \_\_\_\_\_ hours per week
- Self-Employed     Disabled     Retired     Unemployed
- Other (please describe): \_\_\_\_\_

## 24. HOUSEHOLD INCOME

Please use the tables below to describe the total monthly income for your household. Please **provide your monthly gross income (before deductions) rather than your net income**, whether earned by you or another member of your household. Only include household members who contribute income to your household.

**NOT enrolled in Medicaid?** -- You must attach proof of income to this application. For most applicants, this will be a copy of your most recently filed U.S. Income Tax Return. See the instructions for other types of proof of income that is accepted by ADAP. NOTE: For tax year 2014, anyone for who is legally required (and eligible) to file a U.S. tax return will **be expected to do so** to assure their continued assistance with insurance costs. If you are employed and you are not enrolled in Medicare or your employer's health plan, the Employer Insurance Information Form found on page 5 must be filled out, signed, and attached to this recertification form. If your income is \$0, you must attach the Statement of Support, found on page 6.

**Enrolled in Medicaid?** – No further documentation is needed and you do not need to attach the Employer Insurance Information Form or Statement of Support.

Did you, your spouse, or any dependent work this month or expect to work in the next 6 months?  Y  N  
Include temporary/seasonal work and **self-employment NET income (after paying business expenses)**.

Name of Worker (You, Spouse, Dependent, etc.)	Employer Name	Monthly Amount (Gross Amount)	How often are you paid? (Weekly, Every two weeks, Once a month, etc.)
		\$	
		\$	
		\$	

Did you, your spouse, or any dependent receive income from any of these other sources?  Y  N

If yes, check all that apply and fill out this table:

- Unemployment benefits                       SSDI (Supplemental Security Disability Insurance)     Veterans benefits
- Short/Long-term disability                       SSI (Supplemental Security Income)                       Retirement/Pension
- AND (Aid to the Needy Disabled)     TANF (Temporary Aid to Needy Families)                       Taxable trust income
- Workers Compensation                       Interest/Investment Income                       Alimony
- Other (please describe): \_\_\_\_\_

This Check Comes To: (You, Spouse, Dependent, etc.)	Type of Benefit or Income from list above (For example, "SSI")	Monthly Amount (Gross Amount)	How often are you paid? (Weekly, Every two weeks, Once a month, etc.)
		\$	
		\$	
		\$	

**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 agree to notify, or have my case manager notify, the CDPHE of any circumstances affecting my participation in, or eligibility for, ADAP. I understand that I must notify CDPHE of change in my address, insurance status, or income changes exceeding 10% of my wages within 30 (thirty) days. 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 If I participate in either the Health Insurance Assistance Program (HIAP), or Bridging the Gap, Colorado Medicare Assistance Program (BTGC), I voluntarily give my consent to the HIAP administrative agent (Colorado Health Network or its subcontractor, Boulder County Health Network) to release information to, and receive information from, CDPHE/ ADAP, and my insurance carrier and/or receiver of insurance premiums or pharmacy either verbally, or in writing. I understand that both the HIAP and BTGC are component plans of Colorado ADAP, and that my information is contained in a shared database.
- 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 understand that information concerning cases of AIDS, HIV-related illness, laboratory testing, treatment or HIV infection shall be shared, to the minimum extent necessary to achieve the public health purpose, between the appropriate local health department, CDPHE contracted agency or other health agency providing direct HIV related services and CDPHE, as provided by C.R.S. 25-4-1404 (1), (1)(a),(1)(b), (1)(c).
- 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 understand that by applying for insurance through Medicaid or the Connect for Health Colorado database, information about my income, legal residency, and other eligibility factors may be verified by electronic databases located at agencies such as the Internal Revenue Service, Social Security Administration, Colorado Department of Labor, and others. If the information I provide doesn’t match these sources, I will be asked to send proof of my answers.
- 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 I have a right to ask for a full hearing if I feel that a decision on my eligibility was unfair or incorrect or 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**

**Employer Insurance Information Form**

**APPLICANT:** This form is required if you or your spouse are 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.

<b>EMPLOYEE NAME:</b>
<b>EMPLOYER (Business Name):</b>

**To be completed by the EMPLOYER:**

1. Do you offer a health insurance plan to your employee?       Yes     No
2. Does the plan meet the minimum requirements of the Affordable Care Act?       Yes     No     Not Sure  
*If you answer **NO** to either of these questions, skip to the signature portion of this form  
 If you answer **YES** or **NOT SURE**, please fill out the table below and provide a Summary of Benefits of the plan offered*

Employee	<input type="checkbox"/> Not eligible <input type="checkbox"/> Offered, but not accepted <input type="checkbox"/> Offered and accepted	If not eligible, explain if this person <u>could</u> become eligible in the future, and when (e.g., employee becomes full time).  Potential eligibility date: ___/___/____
Spouse Name(s): _____	<input type="checkbox"/> Not eligible <input type="checkbox"/> Offered, but not accepted <input type="checkbox"/> Offered and accepted	If not eligible, explain if this person <u>could</u> become eligible in the future, and when (e.g., employee becomes full time).  Potential eligibility date: ___/___/____
Dependent(s) Name(s): _____ _____	<input type="checkbox"/> Not eligible <input type="checkbox"/> Offered, but not accepted <input type="checkbox"/> Offered and accepted	If not eligible, explain if dependents <u>could</u> become eligible in the future, and when (e.g., employee becomes full time).  Potential eligibility date: ___/___/____

3. What is the date for your company's next open enrollment period? \_\_\_/\_\_\_/\_\_\_\_  
 When does coverage begin after open enrollment? \_\_\_/\_\_\_/\_\_\_\_
4. Has your company's insurance plan benefits recently changed to become compliant with the Affordable Care Act?  
 Yes     No     Not Sure

COMMENTS: \_\_\_\_\_

➔ **PLEASE ATTACH A COPY OF YOUR EMPLOYEE BENEFITS SUMMARY, if available.**

<b>EMPLOYER REPRESENTATIVE COMPLETING THIS FORM:</b>	<b>TITLE:</b>	<b>PHONE:</b>
<b>EMPLOYER'S AUTHORIZED SIGNATURE</b>		<b>DATE:</b>

STATEMENT OF SUPPORT FOR \_\_\_\_\_ (NAME OF APPLICANT)  
**COMPLETE THIS FORM ONLY IF YOU CANNOT PROVIDE PROOF OF RESIDENCY IN YOUR NAME  
OR 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): \_\_\_\_\_

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