# SC ADAP INSURANCE ASSISTANCE APPLICATION

**D H E C**

PROMOTE PROTECT PROSPER

**Return to:**
Insurance Assistance Program (IAP)
3rd Floor, Mills Jarrett
Box 101106, Columbia, SC 29211
PH:   (803)898-0829 or (877) 606-8498
FAX: (803) 898-7683

**Instructions:** This form is for applicants applying for assistance with private/commercial insurance coverage.

## I. APPLICANT INFORMATION                                    ADAP ID:

Last Name: _____ First Name: _____ Full Middle Name: _____

Date of Birth: _____/_____/_____   Social Security #: _____-_____-_____   Gender: _____

If no Social Security #, has applicant lived in SC for at least 3 months?  ○ Yes    ○ No

Street Address 1:_____ Street Address 2: _____

City: _____ State: _____ Zip code: _____ County: _____

Mailing Address:_____ City: _____ Zip: _____

Home Phone (_____) _____ Other Phone (_____) _____

Ethnicity (check one):    ○ Hispanic/Latino (a)    ○ Non-Hispanic/Latino (a)

Race (check all that apply):    ○ Asian    ○ American Indian or Alaskan Native    ○ Black    ○ White
○ Native Hawaiian or Other Pacific Islander    ○ Unknown    ○ Other_____

## II. ELIGIBILITY INFORMATION *(Please attach a separate page for income if more pages are needed for additional household members)*

| Applicant and Other Members in Household | Relationship to Applicant | Gender | Date of Birth | Place of Employment or Source of Other Income | Estimated **Yearly Gross** Income |
|---|---|---|---|---|---|
| *Applicant* | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

*Acceptable documentation:* most current pay stubs, most current W2 forms, most current Federal Tax Return, Pensions, Unemployment Compensation, Social Security Benefits, Alimony, Child Support, Workers Compensation, Wage Statement, or Employer letter (on company letterhead, dated and signed with salary information).

Assets (list only if applying for Insurance Continuation):

Cash/Savings $_____ Stocks/Bonds $_____ Severance Pay $_____ Mutual Funds $_____

## III. CERTIFICATION/CONSENT

1. I certify that the information provided in this application is true and correct to the best of my knowledge.
2. I agree to notify ADAP of any changes to my income or Medicaid/insurance status within 30 days. I will inform ADAP if my address changes or if I choose not to participate in the program.
3. I understand that refusal to use third party resources and/or other requirements are reasons for closure to further program sponsorship.
4. I also understand the importance of taking medications as prescribed and that failure to do so may result in my being  dropped from the program after 60 days. If applicable, I certify that information provided regarding the number of household members, family income and insurance benefits is true and correct to the best of my knowledge.
5. I give permission to ADAP to verify this information, either through written documentation or electronic files.
6. By my signature, I authorize the release of information pertaining to my participation in ADAP to other pharmaceutical companies or pharmacies, as needed. I further authorize the release of information pertaining to my participation in ADAP for the purpose of payment and to the organization(s) associated with the referring physician, referring case manager, and/or case manager if not the referring case manager indicated on the next page.
7. By my signature below as parent, guardian or applicant, I request that payment of Medicare/Medicaid or other third party insurance benefits be made on my behalf to the South Carolina Department of Health and Environmental Control for any services, including STD and/or HIV, provided to me.
8. Permission is also granted to DHEC to exchange the medical or other confidential information as necessary to the Centers for Medicare and Medicaid Services (CMS), its agents or other agents needed to determine these benefits for related services.

_____          _____
Applicant's Signature                                    Date

**APPLICANT NAME:** _____ **DOB:** _____

Does the applicant have medical insurance with prescription coverage?  ○ Yes*  ○ No

**\* If yes, attach a copy of the front and back of insurance card
If applying for Insurance Continuation, attach a copy of the insurance/COBRA policy**

Applying for:   ○ Insurance Copay     **Reimburse Copay To:**  ○ Provider    ○ Pharmacy

○ Insurance Continuation   **Reimburse Premium To:**  ○ Provider

**If applying for Insurance Continuation** (available for individual only): **Monthly Premium:** $_____

Does the applicant have Medicaid coverage?     ○ Yes   ○ No   Medicaid application pending?     ○ Yes   ○ No

Does the applicant have Medicare Part D coverage?  ○ Yes   ○ No   Medicare Part D application pending?  ○ Yes   ○ No

Is the applicant HIV+  ○ Yes    ○ No    Date of diagnosis: _____/_____/_____ or    ○ Unknown

The *most recent* CD4 (T4) lymphocyte count was _____ on _____/_____/_____ (date drawn)

The *most recent* viral load result was _____ on _____/_____/_____ (date drawn)  ○ Pretreatment?  ○ On therapy?

The applicant's current clinical status is: ○ Asymptomatic ○ Symptomatic   Meets the CDC's case definition of AIDS?  ○ Yes ○ No

Check the medications prescribed (applications will be returned as incomplete if no medications are checked)

○ Abacavir (Ziagen)
○ Abacavir, Lamivudine (Epzicom)
○ Abacavir, Lamivudine, Zidovudine (Trizivir)
○ Acyclovir (Zovirax)
○ Amitriptyline (Elavil)
○ Amoxicillan
○ Amoxicillin, Clavulanate (Augmentin)
○ Atazanavir (Reyataz)
○ Atovaquone (Mepron)
○ Azithromycin (Zithromax)
○ Bupropion (Wellbutrin)
○ Ciprofloxacin (Cipro)
○ Citalopram (Celexa)
○ Clarithromycin (Biaxin)
○ Clindamycin (Cleocin)
○ Clotrimazole (Mycelex)
○ Clotrimazole/Betamethasone
○ Dapsone
○ Darunavir (Prezista)
○ Delavirdine (Rescriptor)
○ Didanosine (ddI, Videx)

○ Doxycycline (Vibramycin)
○ Duloxetine (Cymbalta)
○ Efavirenz (Sustiva)
○ Efavirenz, Emtricitabine, Tenofovir (Atripla)
○ Elvitegravir, Cobicistat, Emtricitabine, Tenofovir Disoproxil Fumarate (Stribild)
○ Emtricitabine (Emtriva)
○ Emtricitabine, Tenofovir (Truvada)
○ Enfuvirtide (Fuzeon)
○ Escitalopram (Lexapro)
○ Ethambutol (Myambutol)
○ Etravirine (Intelence)
○ Famciclovir (Famvir)
○ Fluconazole (Diflucan)
○ Fluoxetine (Prozac)
○ Fosamprenavir (Lexiva)
○ Gabapentin (Neurontin)
○ Indinavir (Crixivan)
○ Itraconazole (Sporanox)
○ Ketoconazole (Nizoral)
○ Lamivudine (3TC, Epivir)

○ Lamivudine, Zidovudine (Combivir)
○ Leucovorin
○ Levofloxacin (Levaquin)
○ Lopinavir, Ritonavir (Kaletra)
○ Maraviroc (Selzentry)
○ Metronidazole (Flagyl)
○ Mirtazapine (Remeron)
○ Moxifloxacin (Avelox)
○ Nelfinavir (Viracept)
○ Nevirapine (Viramune)
○ Nystatin (Mycostatin)
○ Nystatin/Triamcinolone
○ Oseltamivir (Tamiflu)
○ Paroxetine (Paxil)
○ Peginterferon (Pegasys)
○ Peginterferon (PEG-Intron)
○ Pravastatin (Pravachol)
○ Prednisone
○ Promethazine
○ Pyrimethamine (Daraprim)
○ Raltegravir (Isentress)
○ Ribavirin (Copegus, Rebetol)

○ Rifabutin (Mycobutin)
○ Rilpivirine (Edurant)
○ Rilpivirine, Emtricitabine, Tenofovir (Complera)
○ Ritonavir (Norvir)
○ Rosuvastatin (Crestor)
○ Saquinavir (Invirase)
○ Sertraline (Zoloft)
○ Simvastatin (Zocor)
○ Stavudine (d4T, Zerit)
○ Sulfadiazine
○ Sulfamethoxazole/TMP (Bactrim DS, Septra DS)
○ Tenofovir (Viread)
○ Tipranavir (Aptivus)
○ Trazodone (Desyrl)
○ Valacyclovir (Valtrex)
○ Valganciclovir (Valcyte)
○ Venlafaxine (Effexor)
○ Voriconazole (Vfend)
○ Zanamivir (Relenza)
○ Zidovudine (AZT, ZDV, Retrovir)

_____  _____  _____  _____  _____
Referring Physician (Print Name)   Signature   Date   Organization  (Please Print)    Phone

_____  _____  _____  _____  _____
Address                City       State    Zip Code   State Medical License#      DEA#

_____  _____  _____  _____  _____
Referring Case Manager (Print Name)  Signature  Date   Organization (Please Print)    Phone

_____  _____  _____  _____  _____
Case Manager if NOT the Referring Case Manager  Signature  Date   Organization  (Please Print)   Phone
(Print Name)

**Purpose**: This form will be used to provide relevant information to determine the applicant's eligibility for the SC ADAP Insurance Assistance Program (IAP).

**Important**:
This form must be completed and signed by the applicant <u>AND</u> the applicant's physician or case manager. All of the supporting documentation (including income documentation) must be submitted with the form.

**Instructions:**
**I. Applicant Information**
*ADAP ID:*  Enter the applicant's ADAP ID, if available.
*Name*:  Enter the applicant's last, first, and full middle name.
*Date of Birth*:  Enter the month, day, and year of the applicant's birth.
*Social Security Number*: Enter the applicant's social security number. Contact the SC ADAP staff if the applicant does not have a social security number.
*Gender*: Enter the applicant's gender (Male, Female, or Transgender).
*If no Social Security # is provided*, indicate if the applicant has lived in SC for at least 3 months.
*Home Address*:  Enter the street address where the applicant lives.  Do not enter a PO Box.
*County*:  Enter the county name where the applicant lives.
*Mailing Address*:  If different from the street address, enter the address (Street or PO Box #) where the applicant wants to receive medications and other correspondence.  *NOTE*: You must notify SC ADAP immediately if there is a change in the mailing address.
*Telephone*:  Enter the area code and telephone number where the applicant can be reached.  Please list both home and work numbers, if possible.  *NOTE*: You must notify SC ADAP immediately if there is a change in the telephone number.
*Ethnicity*:  Enter the applicant's ethnicity.
*Race*:  Enter the applicant's race.

**II. Eligibility Information**
*Financial Data*:  List the following in the table:
    Place of employment, estimated yearly income of the applicant.
    Other members of the household, relationship to the applicant, gender, date of birth, place of employment or source of income. Write "unemployed" if not working - do not write N/A, do not leave blank and do not draw a line through the space.
    Proof of income is required for the applicant and for each member of the household listed in the application.
*NOTE:* The Eligibility Information section is important and must be completed or the form will be returned. Please enter all of the information including a complete list of the household dependents and their individual income documentation (this may be useful in determining if the applicant qualifies for the program).
*Assets:* List only if applying for Insurance Continuation (Cash/Savings, Stocks/Bonds, Severance Pay, Mutual Funds).

**III. Certification and Consent**
*Consent*: This section is mandatory. The applicant must read and understand the conditions for acceptance into the program and sign on the line "*Applicant's Signature*" and date the application.

**IV. Benefits Information**
*Private Medical Insurance*: Check the appropriate box if the applicant has private insurance (through employer, or self).
*NOTE:* Attach copy of insurance card (back and front); if applying for insurance continuation must provide COBRA documentation.

*Copay/Continuation:* Check the appropriate box if the applicant is applying for insurance copay and/or continuation. Select the reimbursement method (to provider/pharmacy).

*Continuation:* Enter the monthly premium amount if applying for IAP continuation. (IAP will only cover health insurance – not dental/vision/etc.).

 *Proof of HAART* may be requested from applicants/providers.

*Medicaid coverage*: Check the appropriate box if the applicant has Medicaid coverage.

*Medicaid application pending:* Check the appropriate box if the applicant's Medicaid application is pending.

*Medicare Part D coverage*: Check the appropriate box if the applicant has Medicare Part D coverage.

*Medicare Part D application pending*: Check the appropriate box if the applicant has an application pending for Med D coverage.


**V. Clinical Information** (This section should be completed by the physician)

*HIV status*: Check the appropriate box for HIV status. Enter date of diagnosis.

*CD4 count:* Enter the most recent CD4 count and the date the blood was drawn.

*Viral load*: Enter the most recent Viral Load information and the date the blood was drawn.

*Clinical status*: Check the appropriate box for the current Clinical Status (Asymptomatic/Symptomatic) and if the applicant meets the CDC's definition for AIDS.

*Medications*: Check the appropriate box(es) for all the drugs being prescribed to the applicant.  Note that SC ADAP will not enroll an applicant unless he/she is on medications.

*Signatures:* All applications MUST be signed by the physician and case manager and/or referring case manager. See below for definitions:

*Referring physician's signature:*  The referring physician must sign and date this section.  The organization name must be printed clearly.

*Referring case manager*: The referring case manager, if applicable, must sign and date this section. The organization name must be printed clearly. The referring case manager is typically the applicant's nurse or social worker who actively monitors the applicant's clinical progress and treatment adherence.

*Case manager if not the referring case manager*: This section is to be completed if the applicant has a case manager who's different from the referring case manager. The case manager should sign and date this section. The organization name must be printed clearly. This case manager is usually a nurse or social worker who assists the applicant with completing the application. In some instances, the application will be forwarded to another nurse or social worker who actively monitors the applicant's clinical progress and treatment adherence.


**Office Mechanics**

*Protected Health Information:* This form contains Protected Health Information (PHI) and should be stored and/or disposed in accordance with your organization's privacy policy. Appropriate forms of storage include but are not limited to: 1) in imaged format and secured in your electronic health record (EHR) system, 2) in paper format in each patient's secure chart/file, 3) shredded in accordance with your organization's privacy policy. This record of disclosure must remain available for a six (6) year retention period.

**Completed applications must be submitted into Provide Enterprise by the enrollee's Case Manager or mailed / faxed to:**

SC ADAP Insurance Assistance Program

3rd Floor, Mills-Jarrett

Box 101106

Columbia, SC 29211


Fax: 803-898-7683

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