New Jersey Department of Health
AIDS Drug Distribution Program (ADDP) and
Health Insurance Premium Payment (HIPP)
PO Box 722
Trenton, NJ 08625-0722

INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR PARTICIPATION IN THE ADDP AND/OR HIPP PROGRAM

Before you begin completing the application form, please take a few minutes to review these specific instructions. While many of the questions are self-explanatory, some require additional clarification to be completed correctly. If you need assistance completing this application, call toll free 1-877-613-4533 for ADDP.

SECTION I - APPLICANT INFORMATION

Enter your principal place of residence.
Seasonal or temporary residence in New Jersey, of whatever duration, does not constitute residency.

Include proof of residence, proof of residency include:

- Motor Vehicle records (e.g., valid Driver's License)
- Lease or mortgage
- Landlord's records and rent receipts
- Public utility records and receipts (electric, gas, phone bill)
- Records of social agencies, public or private
- Employment records
- Social Security records
- Post Office records
- Photo ID from county
- If you are homeless, have case manager/social worker provide support documentation on facility letterhead

You may provide your Social Security number on Page 2 of the application. Although optional, the SSN will help us better coordinate your benefits and speed up processing your application. Providing your Social Security number will also verify eligibility by matching tax files at the New Jersey Division of Taxation, and to identify other prescription coverage by searching health insurance records.

DOMESTIC STATUS:
Check “separated” if:
(1) You and your spouse/partner live apart AND if you do not have access to, or receive support from, your spouse’s/partner’s income;
(2) Your spouse/partner has been confined to a long-term care or psychiatric institution for at least 30 days prior to this application.
If you check “separated,” you must complete Section III

SECTION V – COMMUNICATION

The Certification and Authorization must be dated and signed (or marked) by you, your spouse/partner (if married/civil union).

CONTACT PERSON:
Provide the name of someone we may contact in the event that we are unable to reach you. Please indicate if your contact person is aware of your HIV status.

PREPARER INFORMATION:
Anyone other than the applicant who prepares the form must provide their name and telephone number, in case questions should arise concerning the application.

CASE MANAGER INFORMATION:
It is recommended that all applicants have or consult a case manager determined by county of residence. You may contact your county board of social services or call the Division of HIV, STD and TB Services for a list of funded facilities in your area. ----

SECTION VI – INCOME DETAILS

HOUSEHOLD UNIT:
In calculating the number of people in the household, include:
(1) Yourself, spouse/partner (if married/civil union), AND
(2) All persons whom you claim as a dependent OR all persons who claim you, the applicant, as their dependent.

Enter your **TOTAL HOUSEHOLD INCOME**, by category, for the past 12 months. Enter your income. If you are married or a member of a civil union, enter your income PLUS your spouse's/partner’s income. If you are dependent on others, also enter their total income.

Fill in ALL of the blanks. List gross figures unless otherwise indicated. If your income for any category is zero, write "0" in that space.

If you (and/or your spouse/partner, if married/civil union) have no income, supply a letter of support from the person(s) who provides your support. The letter must specifically state if the person(s) providing your support claims you as a dependent for income tax purposes.

If you and/or your spouse/partner have Medicare Part B premiums deducted monthly from your Social Security check, multiply this amount by 12 (annual amount) and enter it under "Sources of Income." Most individuals who are permanently disabled or over 65 have Medicare Part B deducted from their Social Security check.

Examples of income that also must be reported:

- Business Income (Net)
- Realized Capital Gains
- Inheritance
- Death Benefits Received (Net)
- Royalties

If you need current income limits, call ADDP at 1-877-613-4533 or the Department of Health at 1 (800) 353-3232 or go to: https://www.nj.gov/health/hivstdtb/hiv-aids/medications.shtml

If you or any member of your household filed a Federal, State and/or City Income Tax Return last year, a copy of each completed and signed tax return, including any and all attached schedules, must accompany your application.

If you have applied for Social Security Disability benefits, forward a copy of your Notification of Social Security Disability Entitlement, once received.

SECTION VII – HEALTH INSURANCE DETAILS

Check all that apply regarding your health insurance coverage. If you have "Private Health Insurance" through any source, provide the policy number(s) as well as name and address of the insurance carrier(s). If this coverage is provided by an employer (current or previous) or union, enter the name and address of the employer or union. "Private Health Insurance" includes the health insurance provided by private insurance carriers such as Blue Cross/Blue Shield, Aetna, etc.

You must include a legible photocopy of the front and back of your insurance card(s) and prescription card(s).

CERTIFICATION BY PHYSICIAN (Form DHSTS-37)

Complete the requested information in Section I and forward to your physician for completion of Section II. Make sure that all requested information has been clearly entered. Ask your physician to return the completed form to you. Return the completed certification along with your completed application to ADDP.

Before you begin completing the application form, please take a few minutes to review these specific instructions. While many of the questions are self-explanatory, some require additional clarification to be completed correctly. If you need assistance completing this application, call toll free 1-877-613-4533 for ADDP.

BEFORE YOU MAIL YOUR APPLICATION:

REVIEW THIS CHECKLIST AND MAKE SURE THAT ALL OF THE FOLLOWING ITEMS ARE MAILED WITH YOUR COMPLETED APPLICATION.

IMPORTANT: Send copies of any requested documents. Do not send original documents as they WILL NOT be returned.

Proof of residency

Verification of income (current pay stubs, unemployment records, etc.)

Most recent signed Federal, State and/or City Income Tax Returns, including any and all attached schedules or, if no income tax return filed, submit most recent W-2 form(s), 1099 form(s), etc.

If you receive Social Security Disability benefits, please include the Notice of Award letter.

Copies of the FRONT and BACK of all health insurance/prescription cards

Certification by Physician form (DHSTS-37) (completed and signed)

If applying for assistance with employer sponsored insurance, also include also include current health insurance premium billing notice that includes premium identification, number, premium, amounts, payments due date, and where to send payments.

If you are a COBRA applicant, please include a copy of the completed COBRA election form and/or current COBRA billing invoice.

New Jersey Department of Health
AIDS Drug Distribution Program (ADDP)
PO Box 722
Trenton, NJ 08625-0722

APPLICATION FOR PARTICIPATION IN THE AIDS DRUG DISTRIBUTION PROGRAM AND/OR HEALTH INSURANCE CONTINUATION PROGRAM

APPLICATIONS ARE ACCEPTED ONLY AT THE FOLLOWING ADDRESS:

ADDP
PO Box 722
Trenton, NJ 08625-0722

or fax to: 609-588-7037

If you want more information on the AIDS Drug Distribution Program (ADDP) please go to our websites at:

For ADDP: http://nj.gov/health/aids/freemeds.shtml

IT IS THE CLIENT'S RESPONSIBIITY TO REPORT ANY CHANGES IN CIRCUMSTANCES THAT WOULD IMPACT ELIGIBILITY FOR ADDP.

Please print clearly and answer all questions. Review the attached instructions before you begin. If you need assistance completing this application, call toll free 1-877-613-4533 for ADDP. Mail the completed application to the ADDP/HIPP Program at the address given above or fax to 609-588-7037. Send copies of any requested documents. Do NOT send original documents as they WILL NOT be returned.

SECTION I - APPLICANT INFORMATION	
Residential Address (If homeless leave blank)	Apt. Number
City, State, Zip Code	County
Mailing Address (if different)	
City, State, Zip Code	
Whose mailing address are you using: ☐ Self ☐ Medical Case Manager ☐ Other_____	
Residency a. Is the address above your principal place of residence? ☐ Yes ☐ No ***NOTE: Proof of residency MUST accompany this application. See Instructions.*** ***NO HOME ADDRESS DECLARATION – If you do not have a residential address, you may have a case manager/social worker provide support documentation on facility letterhead.***	

SECTION II - HOUSEHOLD

Directions:

First, provide your birthdate, gender, and marital status. Once Completed, describe other household members. You must do this for all the adults and children under age 21 living in your household. Leave unneeded household member sections blank. The applicant must be HIV+.

If you plan on filing federal income taxes next year: Enter anyone who is filing jointly with you and anyone you intend to claim as your tax dependent, even if that person does not want health coverage or does not live with you. If you will be claimed as a tax dependent by someone else, enter the tax filer and any other dependents the tax filer intends to claim. This information is required to determine your correct household size.

If you DO NOT plan on filing federal income taxes next year:
Enter all the adults who live in your household and all the children under 21 who live in your household or are away at school full-time.

If you want assistance with NJ Marketplace (Get Covered NJ) insurance, you must file a FEDERAL Income tax return. Also, married couples must file jointly.

If you have more than 2 household members, please See Addendum DHSTS-27b

Household Member 1:
Is this the Applicant? ☐ Yes ☐ No

Relationship to Applicant: ☐ Parent ☐ Grandparent ☐ Spouse ☐ Child ☐ Sibling ☐ Applicant ☐ Other: _____

Last Name:	First Name:	MI:	Date of Birth ____/____/____ Month Day Year

Are you legally present? ☐ Yes ☐ No
Undocumented status will not impact your ADDP eligibility. This is to help you get Health Insurance

Social Security Number: _____
Please include the Social Security Number (SSN) for anyone applying for benefits. Although you are not required to provide a SSN at this time, however, providing your SSN will speed up the application process.

Marital Status:
☐ Single ☐ Married ☐ Widowed
☐ Divorced ☐ Civil Union/ Domestic Partner
☐ Separated *(You will need to Verify this information Section III)*

Gender:
☐ Male ☐ Female
☐ Transgendered Male to Female
☐ Transgendered Female to Male
Gender at Birth: ☐ Male ☐ Female

If Pregnant:
No. of babies expected: _____
Due Date: ____/____/____ Month Day Year

Household Member 2:
Is this the Applicant? ☐ Yes ☐ No

Relationship to Applicant: ☐ Parent ☐ Grandparent ☐ Spouse ☐ Child ☐ Sibling ☐ Other: _____

Last Name:	First Name:	MI:	Date of Birth ____/____/____ Month Day Year

Are you legally present? ☐ Yes ☐ No
Undocumented status will not impact your ADDP eligibility. This is to help you get Health Insurance

Social Security Number: _____
Please include the Social Security Number (SSN) for anyone applying for benefits. Although you are not required to provide a SSN at this time, however, providing your SSN will speed up the application process.

Marital Status:
☐ Single ☐ Married ☐ Widowed
☐ Divorced ☐ Civil Union/ Domestic Partner
☐ Separated *(You will need to Verify this information in Section III)*

Gender:
☐ Male ☐ Female
☐ Transgendered Male to Female
☐ Transgendered Female to Male
Gender at Birth: ☐ Male ☐ Female

If Pregnant:
No. of babies expected: _____
Due Date: ____/____/____ Month Day Year

SECTION III – ATTESTATION OF SEPERATION

Fill out this section if applicant was previously in a Marriage/ Civil Union/ Domestic Partnership but is not currently.

I, _____, attest to the truthfulness of the following:
(Print Name of Applicant)

a. That my spouse and I are separated and no longer reside together.
b. I receive no support or monies from my spouse.
c. That my spouse and I do not mingle or join our funds in any way including the filing of joint federal or state income tax returns.

Signature of Applicant	Date

SECTION IV – DEMOGRAPHICS OF APPLICANT

Ethnicity, race, gender identity and sexual orientation questions are optional, but this information helps the DHSTS improve service to all people using this program. We use this information to make sure everyone gets fair access to services. We won't share your information with any government or private entity. We must protect the privacy of your information. Your responses are only accessible to program staff and claims processors. Providing this information won't impact eligibility and it can't be used to discriminate against you or deny you services.

Please identify your race (Check all that apply):

☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian Pacific Islander

Please select your ethnicity: ☐ Non- Hispanic ☐ Hispanic/ Latino(a)	If Hispanic/Latino(a), please specify (Check all that apply): ☐ Puerto Rican ☐ Mexican, Mexican American, Chicano ☐ Cuban ☐ Other Hispanic Origin _____
Are you a Veteran? ☐ Yes ☐ No	Are you being released from an Institution/Hospital? ☐ Yes ☐ No
Is your CD4 count less than 200? ☐ Yes ☐ No	Are you being released from prison? ☐ Yes ☐ No
Signature of Applicant	Date

SECTION V – COMMUNICATION

Applicant Contact Information:

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Please put a check mark next to your preferred contact number

Email: _____

a. May ADDP/HIPP staff leave a detailed voice mail message on *(Check all that apply)*?
   ☐ Home Phone ☐ Cell Phone ☐ Work Phone

b. May ADDP/HIPP staff send text messages?
   ☐ Yes ☐ No

c. May ADDP/HIPP staff contact via Email?
   ☐ Yes ☐ No

Case Manager Information:

☐ Check here if you have a Medical Case Manager

☐ Check here if you give ADDP and HIPP permission to communicate with your Medical Case Manager and leave messages.

Case Manager Last Name:	First Name:	MI:
Work Phone:	Cell Phone:	Email:

Do you have an alternate contact and may ADDP/HIPP staff leave a message? ☐ Yes ☐ No

Alternate Contact Last Name:	First Name:	MI:
Work Phone:	Cell Phone:	Email:

Relationship to Alternate Contact: ☐ Parent ☐ Grandparent ☐ Spouse ☐ Child ☐ Sibling ☐ Friend ☐ Doctor ☐ Other: _____

All communication details are in effect until you notify ADDP of any changes

SECTION VI – INCOME DETAILS

If you have more than 2 household members, please See Addendum DHSTS-27b

Household Member 1:

Name: _____

Do you have Work Income? ☐ Yes ☐ No

Check here if you are medically UNABLE to work. ☐

If you are medically UNABLE to work, how long have you been medically unable to work?

☐ Less than Six Months ☐ Less than Twelve Months ☐ More than Twelve Months

Employment Type: ☐ Work for Employer ☐ Business Owner ☐ Self Employed ☐ Other _____

Have you had change in your employment status in the last 6 months: ☐ Yes ☐ No

If Yes, Why?: ☐ Change of Job ☐ Stopped working ☐ Hours Reduction ☐ Other:_____

Work Type: ☐ Full time (35 or more hours per week) ☐ Seasonal _____

☐ Part time (less than 35 hours per week) (Indicate Months if Seasonal e.g.(1,2,3 means Jan, Feb, March & so on))

Does Employer Provide Health Insurance? ☐ Yes ☐ No

Frequency of Paycheck ☐ Weekly ☐ Every Two Weeks/ Bi-Weekly ☐ Twice per Month ☐ Once per Month

Other Income:

Income Type	**Monthly Income Amount**
Alimony received	$ _____
Cash support from friends OR family	$ _____
Rental Income (money you receive)	$ _____
Interest & dividends	$ _____
Net farming/fishing	$ _____
Pension or annuity	$ _____
Retirement accounts	$ _____
Social Security Disability benefits	$ _____
State disability	$ _____
Unemployment	$ _____
Other:	
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____

Allowable deductions:

Payment Type	**Monthly Payment Amount**
Alimony paid out	$ _____
Student Loan Interest deductions	$ _____
Tuition and Fees	$ _____
Health Saving Account Deduction	$ _____
Educator Expenses	$ _____
Moving Expenses	$ _____
IRA Deduction	$ _____
Other Deduction:	
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____

Please check this box if you plan to file a federal income tax return NEXT YEAR: ☐ Yes ☐ No

(You can still apply for this form even if you don't file income tax return)

Will you file jointly with your Spouse? ☐ Yes ☐ No

If Yes, please enter spouse's name: _____

Will you claim any dependents on your tax return? ☐ Yes ☐ No

If Yes, please add the name of your dependents: _____

(Dependents should be listed as household members)

Did you and/or any member of your household file a Federal, State or City Income Tax return last year? ☐ Yes ☐ No

Were you listed as a dependent on a family member's Federal, State or City Income Tax return last year? ☐ Yes ☐ No

If YES to either question, submit copies of each signed return, including any and all schedules, with this application.

Household Member 2:

Name: _____

Do you have Work Income? ☐ Yes ☐ No

Check here if you are medically UNABLE to work. ☐

If you are medically UNABLE to work, how long have you been medically unable to work?

☐ Less than Six Months ☐ Less than Twelve Months ☐ More than Twelve Months

Employment Type: ☐ Work for Employer ☐ Business Owner ☐ Self Employed ☐ Other _____

Have you had change in your employment status in the last 6 months: ☐ Yes ☐ No

If Yes, Why?: ☐ Change of Job ☐ Stopped working ☐ Hours Reduction ☐ Other:_____

Work Type: ☐ Full time (35 or more hours per week) ☐ Seasonal _____

☐ Part time (less than 35 hours per week) (Indicate Months if Seasonal e.g.(1,2,3 means Jan, Feb, March & so on))

Does Employer Provide Health Insurance? ☐ Yes ☐ No

Frequency of Paycheck ☐ Weekly ☐ Every Two Weeks/ Bi-Weekly ☐ Twice per Month ☐ Once per Month

Other Income:

Income Type	**Monthly Income Amount**
Alimony received	$ _____
Cash support from friends OR family	$ _____
Rental Income (money you receive)	$ _____
Interest & dividends	$ _____
Net farming/fishing	$ _____
Pension or annuity	$ _____
Retirement accounts	$ _____
Social Security Disability benefits	$ _____
State disability	$ _____
Unemployment	$ _____
Other:	
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____

Allowable deductions:

Payment Type	**Monthly Payment Amount**
Alimony paid out	$ _____
Student Loan Interest deductions	$ _____
Tuition and Fees	$ _____
Health Saving Account Deduction	$ _____
Educator Expenses	$ _____
Moving Expenses	$ _____
IRA Deduction	$ _____
Other Deduction:	
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____

Please check this box if you plan to file a federal income tax return NEXT YEAR: ☐ Yes ☐ No

(You can still apply for this form even if you don't file income tax return)

Will you file jointly with your Spouse? ☐ Yes ☐ No

If Yes, please enter spouse's name: _____

Will you claim any dependents on your tax return? ☐ Yes ☐ No

If Yes, please add the name of your dependents: _____

(Dependents should be listed as household members)

Did you and/or any member of your household file a Federal, State or City Income Tax return last year? ☐ Yes ☐ No

Were you listed as a dependent on a family member's Federal, State or City Income Tax return last year? ☐ Yes ☐ No

If YES to either question, submit copies of each signed return, including any and all schedules, with this application.

SECTION VII – HEALTH INSURANCE DETAILS

Do you currently have any type of health insurance?	If yes, is your Insurance Policy through:
☐ Yes ☐ No	☐ Self ☐ Former Employer (COBRA) ☐ Union ☐ Current Employer

Employer or Union Providing Insurance Coverage:

(a) Name: _____

(b) Address: _____

(c) City, State, Zip: _____

(d) Contact Person: _____

(d) Telephone Number: _____

A dedicated pharmacy is required even if not utilized.

If yes, check all types that you **currently** have:

☐ CHIP	Start Date: ____/____/____ (Month/Day/Year)	Expiration date: ____/____/____ (Month/Day/Year)
☐ COBRA **	Start Date: ____/____/____ (Month/Day/Year)	Expiration date: ____/____/____ (Month/Day/Year)
☐ Employer Contributed	Start Date: ____/____/____ (Month/Day/Year)	Expiration date: ____/____/____ (Month/Day/Year)
☐ Marketplace	Start Date: ____/____/____ (Month/Day/Year)	Expiration date: ____/____/____ (Month/Day/Year)
☐ Medicaid	Start Date: ____/____/____ (Month/Day/Year)	Expiration date: ____/____/____ (Month/Day/Year)
☐ Medicare A/B	Start Date: ____/____/____ (Month/Day/Year)	Expiration date: ____/____/____ (Month/Day/Year)
☐ Medicare D	Start Date: ____/____/____ (Month/Day/Year)	Expiration date: ____/____/____ (Month/Day/Year)
☐ Private Insurance*	Start Date: ____/____/____ (Month/Day/Year)	Expiration date: ____/____/____ (Month/Day/Year)
☐ Other: _____ _____	Start Date: ____/____/____ (Month/Day/Year) Start Date: ____/____/____ (Month/Day/Year)	Expiration date: ____/____/____ (Month/Day/Year) Expiration date: ____/____/____ (Month/Day/Year)

Are you applying for or have already applied for health insurance? ☐ Yes ☐ No
If Yes, is the current status, Pending Approved or Denied?

☐ Medicaid	Application Date: ____/____/____ (Month/Day/Year)	Status:
☐ Medicare	Application Date: ____/____/____ (Month/Day/Year)	Status:
☐ Health Insurance Reform Act (Marketplace/Exchange)	Application Date: ____/____/____ (Month/Day/Year)	Status:
☐ Private*/ Off Market	Application Date: ____/____/____ (Month/Day/Year)	Status:

* Private Insurance Definition:
Plans provided by the private insurance (industry;

Blue Cross Blue
Amerihealth, etc.);Or though employer benefits.
;

**COBRA Definition:
COBRA stands for Consolidated Omnibus Budget Reconciliation Act.The law generally as a benefit applies to all group health plans maintained by private-sector employers with 20 or more (e.g. Horizon employees and sponsored by most state and local governments. If elected, COBRA Shield, Aetna,

allows individuals to continue group health coverage that would otherwise be lost due to certain specific events such as termination of employment. COBRA coverage extends from the date of the qualifying event for a limited period of time.

Select the types of coverage you are currently receiving:

Are you currently receiving **Prescription Coverage**? ☐ Yes ☐ No

Is there a cap on the annual amount your insurance provider will pay for medication? ☐ Yes ☐ No

Are you required to use a mail order pharmacy? ☐ Yes ☐ No

Insurance Carrier's name: _____

Policy/Group: _____

Address: _____

Phone #: _____

Identify your relationship to the primary policy holder: ☐ Self ☐ Spouse/ Partner ☐ Child ☐ Other: _____

Primary policy holder's name: _____

Primary's Phone # _____

Primary's SSN: _____

Primary's Address _____
Street Address

_____
City State County Zip Code

Primary's Phone # _____

Are you currently receiving **Medical Coverage**? ☐ Yes ☐ No

Insurance Carrier's name: _____

Policy/Group: _____

Address: _____

Phone #: _____

Identify your relationship to the primary policy holder: ☐ Self ☐ Spouse/ Partner ☐ Child ☐ Other: _____

Primary policy holder's name: _____

Primary's Phone # _____

Primary's SSN: _____

Primary's Address _____
Street Address

_____
City State County Zip Code

Primary's Phone # _____

Are you currently receiving **Dental Coverage**? ☐ Yes ☐ No

Insurance Carrier's name: _____

Policy/Group: _____

Address: _____

Phone #: _____

Identify your relationship to the primary policy holder: ☐ Self ☐ Spouse/ Partner ☐ Child ☐ Other: _____

Primary policy holder's name: _____

Primary's Phone # _____

Primary's SSN: _____

Primary's Address _____
Street Address

_____
City State County Zip Code

Primary's Phone # _____

Are you currently receiving **Vision Coverage**? ☐ Yes ☐ No

Insurance Carrier's name: _____

Policy/Group: _____

Address: _____

Phone #: _____

Identify your relationship to the primary policy holder: ☐ Self ☐ Spouse/ Partner ☐ Child ☐ Other: _____

Primary policy holder's name: _____

Primary's Phone # _____

Primary's SSN: _____

Primary's Address _____
Street Address

_____
City State County Zip Code

Primary's Phone # _____

SECTION VIII - ATTACHMENT DETAILS

According to the information provided on this application, the Applicant and/or Applicant's Spouse may be asked for the documents listed below, as applicable.

An application will not be considered complete until all needed documentation is received.

- ☐ Insurance Card(s)/Prescription Card(s) front and back
- ☐ Proof of Home Address
- ☐ Homeless declaration
- ☐ Signed Income Tax returns including any and all schedules
- ☐ Signed COBRA Election Form and paperwork
- ☐ Medicare card
- ☐ Notice from your insurance carrier regarding Medicare Part D
- ☐ Pay Stubs
- ☐ Unemployment Record
- ☐ Licensed Medical Provider Certificate of Diagnosis
- ☐ Statement of Support (for no income)
- ☐ Divorce Papers
- ☐ Name Change
- ☐ Other relevant documents

_____

_____

_____

_____

_____

_____

NOTE: You MUST include a photocopy of the FRONT and BACK of all your insurance card(s)/prescription card(s) and any notice from your Insurance Company regarding Medicare Part D.

SECTION IX- CERTIFICATION AND AUTHORIZATION BY APPLICANT

By submitting this application,

a. I certify that the information above is true to the best of my knowledge.

b. I will notify (AIDS Drug Distribution Program)/(Health Insurance Premium Program) immediately if: (1) my income changes; (2) I move out of New Jersey; (3) I have an address or telephone number change; (4) if I become eligible for Medicaid/Welfare/PAAD, (5) there is any change in insurance premium or insurance carrier or (6) any other changes that would affect my eligibility to participate in (AIDS Drug Distribution Program)/(Health Insurance Premium Program).

c. I authorize the release of information necessary to determine my AIDS Drug Distribution Program and/or Health Insurance Premium Program or other New Jersey programs eligibility from the records in possession of the Social Security Administration, Internal Revenue Service and New Jersey Division of Taxation, employers, banks, insurance provider and others as the need arises.

d. I authorize my physician to release information concerning prescriptions which have been paid on my behalf by ADDP.

e. I hereby assign the State of New Jersey as my authorized representative to vigorously seek reimbursement of drug benefits to which I may be entitled under any other plan of assistance or insurance, from any other liable third party or other government assistance.

f. I understand that I will be responsible to refund any AIDS Drug Distribution Program and/or Health Insurance Premium Program benefits which are determined to have been incorrectly paid on my behalf..

g. I understand that AIDS Drug Distribution Program and Health Insurance Premium Program reserve the right to limit enrollment based upon the availability of funds.

I declare under penalty of perjury that I have examined all the information on this form, and it is true and correct to the best of my knowledge.

Signature of Applicant	Date
Signature of Spouse/Partner (if income is comingled)	Date

Preparer:
If Anyone other than the applicant prepared the form, they must provide name and telephone number, in case questions should arise concerning the application.

Name of Preparer	Phone
Signature of Preparer	Date

FOR ADDP STAFF USE ONLY:	Date eligibility determined: _____/ _____/ _____