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

INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR PARTICIPATION IN THE ADDP AND/OR HICP 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 questions or 1-800-353-3232 for HICP questions.

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 two (2) proofs of residence, one of which must be no more than 6 months old. Sample proofs 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 must submit your Social Security number which will be used to create a unique identifier to track your application, to provide and record pharmaceutical benefits, to 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,” please fill out and send in DHAS-40 Certification of Separation.

FAMILY SIZE:
Family is defined as anyone who is related to you, the applicant, by blood, marriage, or adoption. To calculate Family Size, include yourself, your spouse (if married and living together) and all people currently living in your household who are related to you.

SECTION II - HOUSEHOLD INCOME

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

Report these in Item #22 in the “Other” category.

INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR PARTICIPATION IN THE AIDS DRUG DISTRIBUTION PROGRAM AND/OR HEALTH INSURANCE CONTINUATION PROGRAM (Continued)

Maximum Allowable Household Income Limits for this ADDP and HICP as of January 2015 are listed below.

If you need current income limits, call 1-877-613-4533.

Federal Poverty Level for January 2015 to January 2016	
Number of Persons in Household	**Maximum Allowable Household Income**
1	$58,850
2	$79,650
3	$100,450
4	$121,250
5	$142,050

For households with more than 5 persons, add $20,800 for each additional person.

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 III - INSURANCE COVERAGE

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, HMO, PPO, etc.

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

SECTION IV - CERTIFICATION AND AUTHORIZATION BY APPLICANT

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 his/her name and telephone number, in case questions should arise concerning the application.

CASE MANAGER INFORMATION:
All applicants should have a case manager determined by county of residence. You may contact your county board of social services or a Ryan White funded facility for a case manager.

CERTIFICATION BY PHYSICIAN (Form DHAS-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.

CERTIFICATION BY PHARMACIST (Form DHAS-38) *(ONLY IF APPLYING FOR ADDP)*

You must make an agreement with a New Jersey Medicaid/PAAD participating pharmacist to dispense FDA-approved drugs on your behalf. Complete the requested information in Section I and forward to your pharmacist for completion of Section II. Make sure that all requested information has been clearly entered. Ask your pharmacist to return the completed form to you. Return the completed certification along with your completed application.

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.

- ☐ Two (2) different proofs 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 (DHAS-37) (completed and signed)
- ☐ Certification by Pharmacist form (DHAS-38) (completed and signed) (only for ADDP)
- ☐ Certification of Separation form (DHAS-40) (completed and signed) if you are separated as defined in these Instructions, page I, Applicant Information, Domestic Status.

- ☐ **If applying for HICP, 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.**

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) or the Health Insurance Continuation Program (HICP), please go to our websites at:

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

For HICP: http://nj.gov/health/aids/keepins.shtml

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

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

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

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 questions or 1-800-353-3232 for HICP questions. Mail the completed application to the ADDP/HICP 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.

☐ **I am also applying for HICP.**

SECTION I - APPLICANT INFORMATION

1. Last Name	First Name	MI	2. Date of Birth ____ / ____ / ____ Month / Day / Year
3. Street Address			Apt. Number
City, State, Zip Code			4. County

5. Mailing Address (if different) Apt. No. City State Zip Code

6. Applicant's Telephone Numbers:

Home: _____ Cell: _____ Work: _____

Telephone Communications

a. May ADDP/HICP staff leave a detailed voice mail message on *(Check all that apply)*?

☐ Home Phone ☐ Cell Phone ☐ Work Phone

b. I do not have a phone but my alternate contact and/or case manager may be contacted and messages left.

☐ Yes ☐ No **Please provide alternate contact information on Page 4.**

7. Residency

a. Is the address above your principal place of residence? ☐ Yes ☐ No

NOTE: Two (2) proofs of residency MUST accompany this application. See Instructions.

NO HOME ADDRESS DECLARATION – If you do not have a home address, have a case manager/social worker provide support documentation on facility letterhead.

8. What is your Social Security Number (if you have one)?

_____

9. Citizenship Status ***(Responding to this question will not affect your eligibility for ADDP.)***

a. Are you a U.S. citizen? ☐ Yes ☐ No

10. Veteran Status

a. Are you a veteran? ☐ Yes ☐ No

11. Relationship Status

☐ Single
☐ Married
☐ Civil Union
☐ Domestic Partner
☐ Divorced
☐ Widowed
☐ Separated*
*(*See Instructions, Page 1, Applicant Information.)*

12. Gender

☐ Male
☐ Female
☐ Transgendered Male to Female
☐ Transgendered Female to Male

13. Gender at Birth

☐ Male
☐ Female

14. Race

☐ White
☐ Black
☐ Asian
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian

☐ American Indian/Alaskan Native
☐ Native Hawaiian/Pacific Islander
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander

☐ Unknown

15. Ethnicity

☐ Hispanic/Latino
- ☐ Mexican, Mexican American, Chicano/a
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Other Hispanic, Latino/a, or Spanish Origin

☐ Non-Hispanic

16. Female Applicants Only:

Are you pregnant? ☐ Yes ☐ No

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(Continued)

SECTION II - HOUSEHOLD INCOME

17. What is your current employment status?

☐ Full time (35 or more hours per week) ☐ Part time(less than 35 hours per week) ☐ Not employed

18. Are you medically UNABLE to work?	19. Medically unable to work LESS than 12 months?	20. Medically unable to work MORE than 12 months?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

21. Number of persons in your household unit (include yourself):

22. List any annual household income:

Salary/Wages	$ _____
Disability Benefits	$ _____
General Assistance	$ _____
Unemployment	$ _____
Social Security	$ _____
Pension/Retirement	$ _____
Alimony/Palimony	$ _____
Other (specify below):	
_____	$ _____
_____	$ _____
_____	$ _____
Total Annual Household Income	$ _____

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

b. 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.

24. Have you applied for or are you currently receiving any of the following? *(Check ALL that apply)*

Applied For	**Receiving**	
☐	☐	Temporary Assistance to Needy Families (TANF)
☐	☐	Supportive Assistance to Individuals and Families (SAIF) Program
☐	☐	Supplemental Security Income (SSI) Program
☐	☐	General Assistance (GA)
☐	☐	Supplemental Nutrition Assistance Program (SNAP) (formerly "Food Stamps")

APPLICATION FOR PARTICIPATION IN THE
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(Continued)

SECTION III - INSURANCE STATUS

25. Do you currently have any type of health insurance?

☐ Yes ☐ No ☐ Don't Know

a. If yes, is your Insurance Policy through:

☐ Current Employer ☐ Former Employer (COBRA) ☐ Union ☐ Self

(1) Employer or Union Providing Insurance Coverage:

(a) Name: _____

(b) Address: _____

(c) City, State, Zip: _____

(d) Contact Person: _____

(d) Telephone Number: _____

b. If yes, check all types that you currently have:

☐ Medicaid ☐ Medicare A/B ☐ Medicare D ☐ Private Insurance * ☐ CHIP

☐ COBRA **

(1) When does it start? ____ / ____ / ____
Month / Day / Year

(2) When does it expire? ____ / ____ / ____
Month / Day / Year

c. When is the next premium due? ____ / ____ / ____
Month / Day / Year

d. Other (specify): _____

e. If you have insurance, does it provide prescription coverage?

☐ Yes ☐ No ☐ Don't Know

(1) If you have prescription drug coverage through insurance, is there a cap on the annual amount your insurance will pay for medications?

☐ Yes ☐ No ☐ Don't Know

(2) If yes, what is the amount of the cap? $ _____

f. Do you have prescription coverage through a mail order company?

☐ Yes ☐ No ☐ Partial

A dedicated pharmacy is required even if not utilized.

26. Are you applying or have you applied for Medicaid?

☐ Yes ☐ No ☐ Don't Know

a. If yes, when did you apply for Medicaid? ____ / ____ / ____ ☐ Unsure

b. Have you received a response? ☐ Yes ☐ No

27. Are you applying or have you applied for Medicare?

☐ Yes ☐ No ☐ Don't Know

a. If yes, when did you apply for Medicare? ____ / ____ / ____ ☐ Unsure

b. Have you received a response?

☐ Yes ☐ No

c. If Yes, have you applied for Medicare Part D (medication coverage)?

☐ Yes ☐ No ☐ Don't Know

(1) If Yes, have you applied for the Low Income Subsidy (LIS)?

☐ Yes ☐ No ☐ Don't Know

* Private Insurance Definition:
Plans provided by the private insurance industry as a benefit of employment or through the Marketplace (e.g. Horizon Blue Cross Blue Shield, Aetna, Amerihealth, etc.).

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

APPLICATION FOR PARTICIPATION IN THE
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(Continued)

SECTION III - INSURANCE STATUS, CONTINUED

28. Are you applying or have you applied for Social Security Income (SSI) or Social Security Disability Income (SSDI)?

☐ Yes, for SSI ☐ Yes, for SSDI ☐ No ☐ Don't Know

a. If yes, when did you apply for SSI/SSDI? ____/____/____ ☐ Unsure

b. Have you received a response? ☐ Yes ☐ No

29. Are you applying or have you applied for insurance through the Health Insurance Reform Act (Marketplace/Exchange)?

☐ Yes ☐ No ☐ Don't Know

a. If yes, when did you apply? ____/____/____ ☐ Unsure

b. Have you received a response? ☐ Yes ☐ No

NOTE: You MUST include a photocopy of the FRONT and BACK of your insurance card(s)/prescription card(s).

Type of Coverage (Check all that apply): ☐ Medical Plan ☐ Prescription Plan ☐ Other (Specify): _____

30. Private Health Insurance

Insurance Carrier: _____

Address: _____

_____

Telephone Number: _____

Policy Number: _____

If provided by Union or employer:

Employer/Union Name: _____

Address: _____

_____

31. Prescription Coverage

Insurance Carrier: _____

Address: _____

_____

Telephone Number: _____

ID Number: _____

What is the Co-Pay Amount? $ _____

What is the Deductible? $ _____

Identify your relationship to the insured: ☐ Self ☐ Spouse/Partner ☐ Child ☐ Other(Specify): _____

Name of Insured: _____ Social Security Number: _____

Street Address, City, State, Zip: _____

County: _____ Telephone Number: ( ) _____

32. a. Are you eligible for Veterans Administration prescription drug benefits? ☐ Yes ☐ No

b. Are you currently receiving prescription drug benefits? ☐ Yes ☐ No

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

APPLICATION FOR PARTICIPATION IN THE
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(Continued)

SECTION IV - CERTIFICATION AND AUTHORIZATION BY APPLICANT

I certify that the information above is true and accurate to the best of my knowledge and I know that I can be prosecuted for perjury if I have intentionally provided false information. I will notify the Program immediately if my/our income rises above legal limits (as stated in the Instructions); if I move from New Jersey; if I change my present residential address or telephone number; if there is any change in premium payments or policy type; if I become Medicaid/Welfare/PAAD eligible; or if there is a change in any other information pertinent to my participation in ADDP and/or HICP. I authorize the release of information necessary to determine my ADDP and/or HICP eligibility from the records in possession of the Social Security Administration, Internal Revenue Service and New Jersey Division of Taxation, employers, banks and others as the need arises. I authorize my physician to release information concerning prescriptions which have been paid on my behalf by ADDP, or my eligibility for HICP. I hereby assign the State of New Jersey as my authorized representative, any right to drug benefits to which I may be entitled under any other plan of assistance or insurance, from any other liable third party or drug benefits under any other plan of governmental assistance. I understand that the ADDP or the HICP is entitled to repayment for incorrectly provided benefits. I further understand that I will be held liable for any ADDP and/or HICP benefits which are determined to have been incorrectly paid on my behalf. **I understand that the ADDP and the HICP reserve the right to limit enrollment based upon the availability of funds.**

33. Signature of Applicant	Date
34. Signature of Spouse/Partner	Date

35. Contact Person:

May the Department of Human Services and the Department of Health contact an alternate person? ☐ Yes ☐ No

In the event that we need information regarding your participation in the program and you are unavailable, please indicate someone we may contact on your behalf.

Is this person aware of your HIV status? ☐ Yes ☐ No

Name of Contact Person		Relationship to Applicant
Street Address, City, State, Zip		
Home Phone	Work Phone	Cell Phone

36. Preparer:

Anyone other than the applicant who prepared the form must provide his/her name and telephone number, in case questions should arise concerning the application.

Name of Preparer	Phone

37. Case Manager Information

Name of Case Manager		Agency Affiliation
Street Address, City, State, Zip		
Work Phone	Fax Number	Cell Phone

Email Address

Case Manager's Email Address: _____ @ _____

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