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

INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR PARTICIPATION IN THE ADDP (DHSTS-27)

Before you begin completing the application form, please take a few minutes to review these specific instructions.
If you need assistance completing this application, call the ADDP toll free number at 1-877-613-4533.
If you are applying for health insurance premium payment you will need to provide additional documents and complete separate forms as listed on page 3 of these instructions.

SECTION I - APPLICANT INFORMATION

Enter your principal place of residence.
If you are unhoused, have your case manager or social worker provide support documentation on facility letterhead.
Seasonal or temporary residence in New Jersey, of whatever duration, does not constitute residency.

Include proof of residence. Following are examples of proof of residency:

- Motor Vehicle records (e.g., valid Driver's License)
- Lease or mortgage or deed
- Landlord's records and rent receipts.
- Public utility records and receipts (electric, gas, phone bill)
- Records of social services agencies, public or private
- Social Security records
- Post Office records
- Photo ID from county
- Employment records

You may provide your Social Security number (SSN) on Page 1 of the application. Although providing it is optional, the SSN will help us better coordinate your benefits and speed up processing your application. Providing your SSN will also enable us 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.

Applicant's Marital Status: (In both Section I and Section II)

Check "separated" if:
(1) You and your spouse or partner live apart AND if you do not have access to, or receive support from, your spouse or partner's income; or
(2) Your spouse or partner has resided in a long-term care or psychiatric institution for at least 30 days prior to the submission of this application.
If you check "separated," you must complete Section III- Attestation of Separation

SECTION II: HOUSEHOLD INFORMATION

State the number of persons in your household, your relationship to each person, and the birthdate, gender, and marital status of each household member. If you have more than two household members, additional sheets are available on the last two pages of this application, at Sections X and XI. You can print out as many copies of these sheets as needed. Then, complete a sheet with information about each additional household member and include it with your completed ADDP application. Leave unneeded household member sections blank. The Applicant must be HIV positive.

HOUSEHOLD MEMBERS are all the adults and children under age 21 living in the Applicant's household (including children living away at school full time).

(1) In calculating the number of people in the household, include:
   a. The applicant, the Applicant's spouse or partner (if married or in a civil union or a domestic partnership), and
   b. All persons whom the Applicant claims as a dependent, OR all persons who claim the Applicant, as their dependent.

(2) If the Applicant plans to file Federal income taxes next year:
   a. Include anyone who is filing jointly with the Applicant and anyone whom the Applicant intends to claim as a tax dependent, even if that person does not want health coverage or does not live with the Applicant.

(3) If the Applicant DOES NOT plan to file Federal income taxes next year:
   a. Include all the adults living in the Applicant's household and all the children under age 21 living in the Applicant's household (including children living away at school full time).
   b. If the applicant wants assistance obtaining Marketplace (Get Covered NJ) insurance, the Applicant must file a FEDERAL Income tax return.

(4) If someone else will claim the Applicant as a tax dependent, include the tax filer and any other dependents whom the tax filer intends to claim.

(5) Married couples must file jointly.

SECTION III — ATTESTATION OF SEPARATION

Fill out this section and sign it if the Applicant is in a marriage, a civil union, or a domestic partnership, but does not reside with the spouse or partner.

SECTION IV – APPLICANT'S DEMOGRAPHICS

Responding to ethnicity, race, gender identity and sexual orientation questions is optional, but this information helps the ADDP improve service to all people using this program. The Department uses this information to make sure everyone gets fair access to services. The Department 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 will not affect your eligibility and it cannot be used to discriminate against you or deny you services.

SECTION V – COMMUNICATION METHODS

Alternate Contact Person:
Provide the name of someone that the ADDP staff can contact if ADDP staff are unable to reach you.
Please indicate whether the alternate contact person is aware of your HIV status.

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 at 1-(800) 353-3232 for a list of funded facilities in your area.

SECTION VI – INCOME INFORMATION

Household Income:

Enter your TOTAL HOUSEHOLD INCOME, by category, for the past 12 months. List gross figures unless otherwise indicated.

(1) Enter your income.

(2) If you are married or in a civil union or domestic partnership, enter your income PLUS the income of your spouse or partner.

(3) If you are dependent on others, also enter the total income of the persons on whom you are dependent.

(4) Fill in ALL the blanks. If your income for any category is zero, write "0" in that space.

(5) If you and/or your spouse or partner have no income, supply a letter of support from the person(s) who provides your support.

a. The letter must specifically state whether the person(s) providing your support claims you as a dependent for income tax purposes.

Following are examples of income that also must be reported:

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

Medicare Part B Deductions: If you and/or your spouse or partner have Medicare Part B premiums deducted monthly from your Social Security check, multiply this amount by 12 (annual amount) and enter the total next to "Other Deductions," under the column that says, "Allowable Deductions."

If you have applied for Social Security Disability benefits, provide a copy of your Notification of Social Security Disability Entitlement, when you receive it.

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.

SECTION VII – HEALTH INSURANCE INFORMATION

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, or AmeriHealth.

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

SECTION VIII – ATTACHMENTS CHECKLIST

Review this section before mailing your application.

SECTION IX - CERTIFICATION AND AUTHORIZATION BY APPLICANT

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.

SECTION X - ADDITIONAL HOUSEHOLD MEMBERS INFORMATION and SECTION XI – ADDITIONAL HOSEHOLD MEMBERS INCOME INFORMATION

These are additional pages to use if you have more than two household members.

CERTIFICATION BY LICENSED HEALTHCARE PROVIDER (Form DHSTS-37)

Complete the requested information in Section I and forward to your Healthcare Provider for completion of Section II. Ask your Health care Provider to return the completed form to you. Submit the completed Certification with your completed ADDP application when you send it to ADDP.

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

- ☐ Proof of residency.
- ☐ Verification of income (current pay stubs, unemployment records, etc.).
- ☐ Most recent signed Federal, State, and/or City Income Tax Returns, including all attached schedules or, if no income tax return was filed, submit the 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 or prescription cards.
- ☐ **Certification of Licensed Health Care Provider (DHSTS-37) (completed and signed).**

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

HEALTH INSURANCE PREMIUM PAYMENT PROGRAM:

Applications for Participation in the Health Insurance Premium Payment Program (HIPP) can be faxed to (609) 984-6495; emailed to hicp@doh.nj.gov; or mailed to:

HIPP Program
NJ Department of Health
PO Box 363
08625-0363

If you are enrolled in the Get Covered NJ insurance plan, please complete the HIPP Program application forms, which can be obtained from a treatment facility. Your case manager will help you complete the HIPP Program application and submit it on your behalf to the HIPP Program.

If you are applying for assistance with employer-sponsored insurance, please include your current health insurance premium billing notice that includes a premium identification number, premium amounts, the payment due date, and where to send payments. Contact the HIPP program at 1-800-353-3232 for further instructions.

If you are a COBRA applicant, please include a copy of your completed COBRA election form and/or your current COBRA billing invoice. Contact the HIPP program at 1-800-353-3232 for further instructions.

APPLICATION FOR PARTICIPATION IN THE AIDS DRUG DISTRIBUTION PROGRAM

APPLICATIONS ARE ACCEPTED ONLY AT THE FOLLOWING ADDRESS:

ADDP PO Box 722
Trenton, NJ 08625-0722
or fax to: 609-588-7037

For more information on the AIDS Drug Distribution Program (ADDP) please go to our website at:

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

IT IS THE APPLICANT'S RESPONSIBIITY TO REPORT ANY CHANGE IN CIRCUMSTANCES THAT WOULD AFFECT THE APPLICANT'S ELIGIBILITY FOR ADDP

Are you also applying for HIPP? ☐ **Yes** ☐ **No**

SECTION I – APPLICANT INFORMATION			
Applicant's Last Name:	Applicant's First Name:	Middle Initial:	Applicant's Date of Birth: _____ *Month Day Year*
Is the applicant a US citizen? ☐ Yes ☐ No Is the applicant legally present in the USA? ☐ Yes ☐ No *(Undocumented status will not affect the Applicant's ADDP eligibility. This is to help the applicant get Health Insurance)*		Applicant's Social Security Number (optional) : _____ *(Please provide your Social Security Number (SSN). Although this is optional, providing your SSN will speed up the application process).*	
Applicant's Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Civil Union ☐ Domestic Partnership ☐ Separated* **(The Applicant will need to Verify this information in Section III).*	Applicant's Gender Identity: (Select all that apply) ☐ Male ☐ Female ☐ Transgender ☐ Gender Non-Binary Sex Assigned at Birth: ☐ Male ☐ Female	If the Applicant is Pregnant: No. of babies expected: _____ Due Date: _____ *Month Day Year*	
Applicant's Residential Address (If unhoused leave blank; see note below)			Apartment Number
City, State, Zip Code			County
Mailing Address (if different)			
City, State, Zip Code		Applicant's Email:	
Whose mailing address is the Applicant using? ☐ Self ☐ Medical Case Manager ☐ Other (specify): _____			
Is the Residential Address, above, the Applicant's principal place of residence? ☐ Yes ☐ No			
NOTE: Proof of residency MUST accompany this application. See Instructions. ***NO HOME ADDRESS DECLARATION: If the Applicant does not have a residential address, the applicant may have a case manager, or a social worker provide supporting documentation on facility letterhead.***			

SECTION II – HOUSEHOLD MEMBER INFORMATION

How many household members does the Applicant have? _____

Household Member 1

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

Last Name	First Name	MI	Date of Birth (Month Day Year)

Is the household member a US citizen? ☐ Yes ☐ No

Is the household member legally present in the USA? ☐ Yes ☐ No

(Undocumented status will not affect the Applicant's ADDP eligibility. This is to help the applicant get Health Insurance)

Household member's Social Security Number (optional): _____

Please provide your Social Security Number (SSN). Although this is optional, providing your SSN will speed up the application process.

Household member's Marital Status:
☐ Single ☐ Married ☐ Widowed
☐ Divorced ☐ Civil Union
☐ Domestic Partnership
☐ Separated*

**(Applicant will need to Verify this information in Section III)*

Household member's Gender Identity:
(Select all that apply)
☐ Male ☐ Female
☐ Transgender
☐ Gender Non-Binary

Sex Assigned at Birth: ☐ Male ☐ Female

If the household member is pregnant:

No. of babies expected: _____

Due Date: _____ (Month Day Year)

Household Member 2

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

Last Name	First Name	MI	Date of Birth (Month Day Year)

Is the household member a US citizen? ☐ Yes ☐ No

Is the household member legally present in the USA? ☐ Yes ☐ No

(Undocumented status will not affect the Applicant's ADDP eligibility. This is to help the applicant get Health Insurance)

Household member's Social Security Number (optional): _____

Please provide your Social Security Number (SSN). Although this is optional, providing your SSN will speed up the application process.

Household member's Marital Status:
☐ Single ☐ Married ☐ Widowed
☐ Divorced ☐ Civil Union
☐ Domestic Partnership
☐ Separated*

**(Applicant will need to Verify this information in Section III)*

Household member's Gender Identity:
(Select all that apply)
☐ Male ☐ Female
☐ Transgender
☐ Gender Non-Binary

Sex Assigned at Birth: ☐ Male ☐ Female

If the household member is pregnant:

No. of babies expected: _____

Due Date: _____ (Month Day Year)

SECTION III – ATTESTATION OF SEPARATION

Fill out this section if the applicant is in a Marriage, a Civil Union or a Domestic Partnership but does not reside with the spouse or partner.

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

1. My spouse or partner and I are separated and no longer reside together.
2. I receive no support or monies from my spouse or partner.
3. My spouse or partner 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: _____ Dated: _____

SECTION IV - APPLICANT'S DEMOGRAPHICS

Responding to these questions about the applicant's ethnicity, race, gender identity and sexual orientation questions are optional, but this information helps the NJ Department of Health improve service to all people using this program. The Department uses this information to make sure everyone gets fair access to services. We will not 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 will not impact eligibility and it cannot be used to discriminate against you or deny you services.

What is your race and/or ethnicity? Select all that apply and enter additional details in the spaces below.

☐ American Indian or Alaska Native
Enter, for example, Navajo Nation, Blackfeet Tribe of the Blackfeet Indian Reservation of Montana, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, Aztec, Maya, etc.

☐ Asian *Enter, for example, Chinese, Asian Indian, Filipino, Vietnamese, Korean, Japanese, etc.*	☐ Black or African American *Enter, for example, African American, Jamaican, Haitian, Nigerian, Ethiopian, Somali, etc.*
☐ Hispanic or Latino *Enter, for example, Mexican, Puerto Rican, Salvadoran, Cuban, Dominican, Guatemalan, etc.*	☐ Middle Eastern or North African *Enter, for example, Lebanese, Iranian, Egyptian, Syrian, Iraqi, Israeli, etc.*
☐ Native Hawaiian or Pacific Islander *Enter, for example, Native Hawaiian, Samoan, Chamorro, Tongan, Fijian, Marshallese, etc.*	☐ White *Enter, for example, English, German, Irish, Italian, Polish, Scottish, etc.*

Are you a Veteran?	☐ Yes ☐ No	Are you being released from an Institution or a Hospital?	☐ Yes ☐ No
Is your CD4 count less than 200?	☐ Yes ☐ No	Are you being released from prison or a correctional facility?	☐ Yes ☐ No

SECTION V – COMMUNICATION METHODS

Applicant's Contact Information:

Home Phone: _____ Cell Phone: _____

Please put a check mark next to your preferred contact number

Work Phone: _____ Email: _____

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

☐ Home Phone ☐ Cell Phone ☐ Work Phone

Indicate whether ADDP and HIPP staff may send text messages to your cell phone: ☐ Yes ☐ No

Indicate whether ADDP and HIPP staff may contact you via email: ☐ Yes ☐ No

Alternate Contact Information:

☐ Check here if you have an alternate contact with whom ADDP and HIPP Program staff may leave messages.

Does this person know your HIV status? ☐ Yes ☐ No

Relationship to Alternate Contact: ☐ Parent ☐ Grandparent ☐ Spouse or Partner ☐ Child ☐ Sibling ☐ Friend ☐ Health care provider ☐ Other (specify): _____

Alternate Contact Last Name: _____ First Name: _____ Middle Initial: _____

Provide the methods by which ADDP and HIPP Program staff may communicate with your alternate contact (*check the box next to the preferred method*)

Work Phone: _____ Cell Phone: _____

Email: _____ Other: _____

Medical Case Manager (MCM) Information:

☐ Check here if you have a Medical Case Manager

☐ Check here if you give the ADDP and the HIPP Program permission to communicate with your MCM and leave messages.

Case Manager Last Name: _____ First Name: _____ Middle Initial: _____

Work Phone: _____ Cell Phone: _____

Email: _____ Other: _____

SECTION VI – INCOME INFORMATION

Applicant's Income Information

Are you currently employed? ☐ Yes ☐ No

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

Have you had change in your employment status in the last six 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) **If Seasonal, indicate Months you work (1,2,3 means Jan, Feb, March & so on)*

Frequency of Paycheck: ☐ Weekly ☐ Every Two Weeks ☐ Once per Month

Does your employer provide health insurance? ☐ Yes ☐ No

If you are not employed, are you medically unable to work? ☐ Yes ☐ No

If Yes, how long have you been medically unable to work? ☐ Less than Six Months ☐ Less than Twelve Months ☐ More than Twelve Months

Other Income:

Income Type	Monthly Income Amount
Alimony	$ _____
Cash support from friends OR family	$ _____
Rental Income	$ _____
Interest & dividends	$ _____
Net income from farming/fishing	$ _____
Pension or annuity	$ _____
Retirement account	$ _____
Social Security benefit	$ _____
State Disability benefit	$ _____
Unemployment benefit	$ _____
Other Income (specify type):	
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____

Allowable deductions:

Payment Type	Monthly Payment Amount
Alimony	$ _____
Student Loan Interest deduction	$ _____
Tuition and Fees	$ _____
Health Savings Account Deduction	$ _____
Educator Expenses	$ _____
Moving Expenses	$ _____
IRA Deduction	$ _____
Other Deduction (specify type):	
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____

Please check this box if you plan to file a Federal Income tax return NEXT YEAR: ☐ Yes ☐ No
(You can still apply to participate in the ADDP even if you will not file an income tax return)

Will you file jointly with your spouse or partner? ☐ Yes ☐ No

If Yes, please enter spouse or partner'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 included 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 you answer YES to either of the last two questions, submit copies of each signed return, including all schedules, with this application.

SECTION VI – INCOME INFORMATION (Continued)

Household Member 1 Income Information: Name of Household Member 1: _____

Are you currently employed? ☐ Yes ☐ No

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

Have you had change in your employment status in the last six month? ☐ 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) **If Seasonal, indicate Months you work (1,2,3 means Jan, Feb, March & so on)*

Frequency of Paycheck: ☐ Weekly ☐ Every Two Weeks ☐ Once per Month

Does your Employer provide health insurance? ☐ Yes ☐ No

If you don't have work income, are you medically unable to work? ☐ Yes ☐ No

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

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

Other Income:

Income Type	Monthly Income Amount
Alimony	$ _____
Cash support from friends OR family	$ _____
Rental Income	$ _____
Interest & dividends	$ _____
Net income from farming/fishing	$ _____
Pension or annuity	$ _____
Retirement account	$ _____
Social Security benefit	$ _____
State Disability benefit	$ _____
Unemployment benefit	$ _____
Other Income (specify type):	
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____

Allowable deductions:

Payment Type	Monthly Payment Amount
Alimony	$ _____
Student Loan Interest deduction	$ _____
Tuition and Fees	$ _____
Health Savings Account Deduction	$ _____
Educator Expenses	$ _____
Moving Expenses	$ _____
IRA Deduction	$ _____
Other Deduction (specify type):	
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____

Please check this box if you plan to file a Federal Income tax return NEXT YEAR: ☐ Yes ☐ No
(You can still apply to participate in the ADDP even if you will not file an income tax return)

Will you file jointly with your spouse or partner? ☐ Yes ☐ No

If Yes, please enter spouse or partner'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 included 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 you answer YES to either of the last two questions, submit copies of each signed return, including all schedules, with this application.

SECTION VI – INCOME INFORMATION (Continued)

Household Member 2 Income Information: Name of Household Member 2: _____

Are you currently employed? ☐ Yes ☐ No

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

Have you had change in your employment status in the last six 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) **If Seasonal,. indicate Months you work (1,2,3 means Jan, Feb, March & so on)*

Frequency of Paycheck: ☐ Weekly ☐ Every Two Weeks ☐ Once per Month

Does Employer provide health insurance? ☐ Yes ☐ No

If you don't have work income, are you medically unable to work? ☐ Yes ☐ No

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

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

Other Income:

Income Type	Monthly Income Amount
Alimony	$ _____
Cash support from friends OR family	$ _____
Rental Income	$ _____
Interest & dividends	$ _____
Net income from farming/fishing	$ _____
Pension or annuity	$ _____
Retirement account	$ _____
Social Security benefit	$ _____
State Disability benefit	$ _____
Unemployment benefit	$ _____
Other Income (specify type):	
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____

Allowable deductions:

Payment Type	Monthly Payment Amount
Alimony	$ _____
Student Loan Interest deduction	$ _____
Tuition and Fees	$ _____
Health Savings Account Deduction	$ _____
Educator Expenses	$ _____
Moving Expenses	$ _____
IRA Deduction	$ _____
Other Deduction (specify type):	
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____

Please check this box if you plan to file a Federal Income tax return NEXT YEAR: ☐ Yes ☐ No
(You can still apply to participate in the ADDP even if you will not file an income tax return)

Will you file jointly with your spouse or partner? ☐ Yes ☐ No

If Yes, please enter spouse or partner'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 included 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 you answer YES to either of the last two questions, submit copies of each signed return, including all schedules, with this application.

SECTION VII – HEALTH INSURANCE INFORMATION

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

Provide the following information about the Employer or Union Providing Health Insurance Coverage:

(a) Name: _____

(b) Mailing Address: _____

(c) City, State, Zip: _____

(d) Contact Person: _____

(d) Telephone Number: _____

Applicant's Pharmacy *(Applicant must specify the pharmacy to be used to fill prescriptions):*

(a) Name: _____

(b) City, State, Zip: _____

(c) Telephone Number: _____

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*	Expiration date: ____ ____ ____ *Month Day Year*
☐ Other: _____	Start Date: ____ ____ ____ *Month Day Year*	Expiration date: ____ ____ ____ *Month Day Year*

* "COBRA Definition":

COBRA stands for Consolidated Omnibus Budget Reconciliation Act. The law applies to all group health plans maintained by private-sector employers with 20 or more employees and sponsored by most state and local governments. COBRA allows individuals to elect 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.

** "Private Insurance" Definition:

Plans provided by the private insurance industry as a benefit of employment or through the Marketplace, such as Horizon Blue Cross Blue Shield, Aetna, or AmeriHealth.

SECTION VII – HEALTH INSURANCE INFORMATION (continued)

Are you applying for or have already applied for health insurance? ☐ Yes ☐ No

If Yes, is the current status of your application, Pending, Approved, or Denied?

Type of Coverage Applied for *(check the box for each type of coverage for which the Applicant has a pending application)*	**Application Date**	**Application Status**
☐ Medicaid	Month Day Year	
☐ Medicare	Month Day Year	
☐ Health Insurance Reform Act (Marketplace/Exchange)	Month Day Year	
☐ Private*/ Off Market	Month Day Year	

Do you currently have **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 Number: _____

Address: _____

Telephone Number: _____

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

Primary policy holder's name: _____

Primary Policy Holder's Telephone Number _____

Primary Policy Holder's Social Security Number: _____

Primary Policy Holder's Street Address _____

_____

City State County Zip Code

Do you currently have **Medical Insurance Coverage**? ☐ Yes ☐ No

Insurance Carrier's name: _____

Policy/Group Number: _____

Address: _____

Telephone Number: _____

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

Primary policy holder's name: _____

Primary Policy Holder's Telephone Number _____

Primary Policy Holder's Social Security Number: _____

Primary Policy Holder's Street Address _____

_____

City State County Zip Code

Do you currently have **Dental Insurance Coverage**? ☐ Yes ☐ No

Insurance Carrier's name: _____

Policy/Group Number: _____

Address: _____

Telephone Number: _____

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

Primary policy holder's name: _____

Primary Policy Holder's Telephone Number _____

Primary Policy Holder's Social Security Number: _____

Primary Policy Holder's Street Address _____

_____
City State County Zip Code

Do you currently have **Vision Coverage**? ☐ Yes ☐ No

Insurance Carrier's name: _____

Policy/Group Number: _____

Address: _____

Telephone Number: _____

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

Primary policy holder's name: _____

Primary Policy Holder's Telephone Number _____

Primary Policy Holder's Social Security Number: _____

Primary Policy Holder's Street Address _____

_____
City State County Zip Code

SECTION VIII - ATTACHMENTS CHECKLIST

Depending on the information provided on this application, the Applicant and/or Applicant's Spouse or Partner may be asked for copies of 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 (front and back).
- Pay Stubs.
- Unemployment Record.
- Certificate of Licensed Health care 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) and prescription card(s).

SECTION IX - CERTIFICATION AND AUTHORIZATION BY APPLICANT

By Submitting this application:

1. I certify that the information above is true to the best of my knowledge.
2. I will notify (AIDS Drug Distribution Program)/(Health Insurance Premium Payment Program) immediately if:
    a) My income changes;
    b) I move out of New Jersey;
    c) I have an address or telephone number change;
    d) I become eligible for Medicaid/Welfare/PAAD;
    e) There is a change in insurance premium or insurance carrier; or
    f) Any other change occurs that would affect my eligibility to participate in the ADDP or the HIPP Program;
3. I authorize the release of information necessary to determine my eligibility for the ADDP or the HIPP Program; from the records in possession of the Social Security Administration, the Internal Revenue Service, the New Jersey Division of Taxation, my employers, my banks, and my insurance providers.
4. I authorize my Health Care Provider and other entities that have financial or health insurance information to release information concerning prescriptions for which the ADDP has paid on my behalf.
5. I hereby appoint 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 source of government assistance.
6. I understand that I am responsible for refunding benefits to the ADDP and, if applicable, the HIPP Program if benefits are determined to have been incorrectly paid on my behalf by the ADDP or the HIPP Program; and
7. I understand that the ADDP and the HIPP 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 or Partner (if income is commingled)	Date

Name of Preparer	Preparer's Telephone Number:
Signature of Preparer	Date

FOR ADDP STAFF USE ONLY:	Date eligibility determined:

Only complete this page if you have more than 2 household members. You can print out as many copies of this page as needed. Complete the information for other household members and enclose them with your completed ADDP application.

SECTION X – ADDITIONAL HOUSEHOLD MEMBERS INFORMATION

Household Member #_____

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

Last Name	First Name	MI	Date of Birth
			Month Day Year

Is the household member a US Citizen? ☐ Yes ☐ No

Is the household member legally present in the USA? ☐ Yes ☐ No

(Undocumented status will not affect the Applicant's ADDP eligibility. This is to help the applicant get Health Insurance)

Household member's Social Security Number (optional): _____

Please provide your Social Security Number (SSN). Although optional, providing your SSN will speed up the application process.

Household member's Marital Status:
☐ Single ☐ Married ☐ Widowed
☐ Divorced ☐ Civil Union
☐ Domestic Partnership
☐ Separated*

(Applicant will need to Verify this information in Section III)

Household member's Gender Identity:
(Select all that apply)
☐ Male ☐ Female
☐ Transgender
☐ Gender Non-Binary

Sex Assigned at Birth:
☐ Male ☐ Female

If household member' is pregnant:

No. of babies expected: _____

Due Date: _____
Month Day Year

Household Member #_____

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

Last Name	First Name	MI	Date of Birth
			Month Day Year

Is the household member a US Citizen? ☐ Yes ☐ No

Is the household member legally present in the USA? ☐ Yes ☐ No

(Undocumented status will not affect the Applicant's ADDP eligibility. This is to help the applicant get Health Insurance)

Household member's Social Security Number (optional): _____

Please provide your Social Security Number (SSN). Although optional, providing your SSN will speed up the application process.

Household member's Marital Status:
☐ Single ☐ Married ☐ Widowed
☐ Divorced ☐ Civil Union
☐ Domestic Partnership
☐ Separated*

(Applicant will need to Verify this information in Section III)

Household member's Gender Identity:
(Select all that apply)
☐ Male ☐ Female
☐ Transgender
☐ Gender Non-Binary

Sex Assigned at Birth:
☐ Male ☐ Female

If household member' is pregnant:

No. of babies expected: _____

Due Date: _____
Month Day Year

SECTION XI – ADDITIONAL HOUSEHOLD MEMBER INCOME INFORMATION

Household Member #____ Income Information: Name of Household Member: _____

Are you currently employed? ☐ Yes ☐ No

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

Have you had change in your employment status in the last six 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) (If Seasonal, indicate the Months you work (1,2,3 means Jan, Feb, March & so on).

Frequency of Paycheck: ☐ Weekly ☐ Every Two Weeks ☐ Once per Month

Does Employer provide health insurance? ☐ Yes ☐ No

If you don't have work income, are you medically unable to work? ☐ Yes ☐ No

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

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

Other Income:

Income Type	Monthly Income Amount
Alimony	$ _____
Cash support from friends OR family	$ _____
Rental Income	$ _____
Interest & dividends	$ _____
Net income from farming/fishing	$ _____
Pension or annuity	$ _____
Retirement account	$ _____
Social Security benefit	$ _____
State Disability benefit	$ _____
Unemployment benefit	$ _____
Other Income (specify type):	
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____

Allowable deductions:

Payment Type	Monthly Payment Amount
Alimony	$ _____
Student Loan Interest deduction	$ _____
Tuition and Fees	$ _____
Health Savings Account Deduction	$ _____
Educator Expenses	$ _____
Moving Expenses	$ _____
IRA Deduction	$ _____
Other Deduction (specify type):	
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____

Please check this box if you plan to file a Federal Income tax return NEXT YEAR: ☐ Yes ☐ No
(You can still apply to participate in the ADDP even if you will not file an income tax return)

Will you file jointly with your spouse or partner? ☐ Yes ☐ No

If Yes, please enter spouse or partner'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 included 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 you answer YES to either of the last two questions, submit copies of each signed return, including all schedules, with this application.