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

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.

<table>
<thead>
<tr>
<th>Number of Persons in Household</th>
<th>Maximum Allowable Household Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$58,850</td>
</tr>
<tr>
<td>2</td>
<td>$79,650</td>
</tr>
<tr>
<td>3</td>
<td>$100,450</td>
</tr>
<tr>
<td>4</td>
<td>$121,250</td>
</tr>
<tr>
<td>5</td>
<td>$142,050</td>
</tr>
</tbody>
</table>

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.

PREPARATOR 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 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 RESPONSIBILITY TO REPORT ANY CHANGES IN CIRCUMSTANCES THAT WOULD IMPACT ELIGIBILITY FOR ADDP OR HICP.
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.

<table>
<thead>
<tr>
<th>SECTION I - APPLICANT INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Last Name</td>
</tr>
<tr>
<td>2. Date of Birth</td>
</tr>
<tr>
<td>3. Street Address</td>
</tr>
<tr>
<td>City, State, Zip Code</td>
</tr>
<tr>
<td>6. Applicant’s Telephone Numbers:</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>a. May ADDP/HICP staff leave a detailed voice mail message on (Check all that apply)?</td>
</tr>
<tr>
<td>□ Home Phone</td>
</tr>
<tr>
<td>□ Cell Phone</td>
</tr>
<tr>
<td>□ Work Phone</td>
</tr>
<tr>
<td>b. I do not have a phone but my alternate contact and/or case manager may be contacted and messages left.</td>
</tr>
<tr>
<td>□ Yes</td>
</tr>
<tr>
<td>□ No</td>
</tr>
<tr>
<td>7. Residency</td>
</tr>
<tr>
<td>a. Is the address above your principal place of residence?</td>
</tr>
<tr>
<td>□ Yes</td>
</tr>
<tr>
<td>□ No</td>
</tr>
<tr>
<td><strong>NO HOME ADDRESS DECLARATION – If you do not have a home address, have a case manager/social worker provide support documentation on facility letterhead.</strong></td>
</tr>
<tr>
<td>8. What is your Social Security Number (if you have one)?</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>9. Citizenship Status (Responding to this question will not affect your eligibility for ADDP.)</td>
</tr>
<tr>
<td>a. Are you a U.S. citizen?</td>
</tr>
<tr>
<td>10. Veteran Status</td>
</tr>
<tr>
<td>a. Are you a veteran?</td>
</tr>
<tr>
<td>11. Relationship Status</td>
</tr>
<tr>
<td>□ Single</td>
</tr>
<tr>
<td>□ Married</td>
</tr>
<tr>
<td>□ Civil Union</td>
</tr>
<tr>
<td>□ Domestic Partner</td>
</tr>
<tr>
<td>□ Divorced</td>
</tr>
<tr>
<td>□ Widowed</td>
</tr>
<tr>
<td>□ Separated* (*See Instructions, Page 1, Applicant Information.)</td>
</tr>
<tr>
<td>12. Gender</td>
</tr>
<tr>
<td>□ Male</td>
</tr>
<tr>
<td>□ Female</td>
</tr>
<tr>
<td>□ Transgendered Male to Female</td>
</tr>
<tr>
<td>□ Transgendered Female to Male</td>
</tr>
<tr>
<td>13. Gender at Birth</td>
</tr>
<tr>
<td>□ Male</td>
</tr>
<tr>
<td>□ Female</td>
</tr>
<tr>
<td>14. Race</td>
</tr>
<tr>
<td>□ White</td>
</tr>
<tr>
<td>□ Black</td>
</tr>
<tr>
<td>□ Asian</td>
</tr>
<tr>
<td>□ Asian Indian</td>
</tr>
<tr>
<td>□ Chinese</td>
</tr>
<tr>
<td>□ Vietnamese</td>
</tr>
<tr>
<td>□ Filipino</td>
</tr>
<tr>
<td>□ Japanese</td>
</tr>
<tr>
<td>□ American Indian/Alaskan Native</td>
</tr>
<tr>
<td>□ Native Hawaiian/Pacific Islander</td>
</tr>
<tr>
<td>□ Native Hawaiian</td>
</tr>
<tr>
<td>□ Guamanian or Chamorro</td>
</tr>
<tr>
<td>□ Samoan</td>
</tr>
<tr>
<td>□ Other Pacific Islander</td>
</tr>
<tr>
<td>□ Unknown</td>
</tr>
<tr>
<td>15. Ethnicity</td>
</tr>
<tr>
<td>□ Hispanic/Latino</td>
</tr>
<tr>
<td>□ Mexican, Mexican American, Chicano/a</td>
</tr>
<tr>
<td>□ Puerto Rican</td>
</tr>
<tr>
<td>□ Cuban</td>
</tr>
<tr>
<td>□ Other Hispanic, Latino/a, or Spanish Origin</td>
</tr>
<tr>
<td>□ Non-Hispanic</td>
</tr>
<tr>
<td>16. Female Applicants Only:</td>
</tr>
<tr>
<td>Are you pregnant?</td>
</tr>
</tbody>
</table>

DHAS-27
APR 15
-1-
### 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?
- [ ] Yes
- [ ] No

19. Medically unable to work LESS than 12 months?
- [ ] Yes
- [ ] No

20. Medically unable to work MORE than 12 months?
- [ ] Yes
- [ ] No

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

22. List any annual household income:

<table>
<thead>
<tr>
<th>Income Source</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salary/Wages</td>
<td>$</td>
</tr>
<tr>
<td>Disability Benefits</td>
<td>$</td>
</tr>
<tr>
<td>General Assistance</td>
<td>$</td>
</tr>
<tr>
<td>Unemployment</td>
<td>$</td>
</tr>
<tr>
<td>Social Security</td>
<td>$</td>
</tr>
<tr>
<td>Pension/Retirement</td>
<td>$</td>
</tr>
<tr>
<td>Alimony/Palimony</td>
<td>$</td>
</tr>
<tr>
<td>Other (specify below)</td>
<td>$</td>
</tr>
</tbody>
</table>

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)

- [ ] 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”)
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
AIDS DRUG DISTRIBUTION PROGRAM AND/OR HEALTH INSURANCE CONTINUATION PROGRAM

(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).

<table>
<thead>
<tr>
<th>Type of Coverage (Check all that apply):</th>
<th>[ ] Medical Plan</th>
<th>[ ] Prescription Plan</th>
<th>[ ] Other (Specify):</th>
</tr>
</thead>
</table>

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? $ [ ]

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.
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: _____ / _____ / _________