New Jersey Department of Health
Division of HIV, STD and TB Services
HIV Home Care Program

INSTRUCTIONS FOR COMPLETION OF THE APPLICATION FOR ELIGIBILITY FOR THE HIV HOME CARE PROGRAM (DHAS-8)

The following instructions are numerically keyed to the various sections on pages 1 through 4 of the Application for Eligibility form.

SECTION I – APPLICANT INFORMATION

1. Enter your full name.

2. Enter your sex.

3. Enter your date of birth.

4. Enter the street address where services will be provided.

5. Enter your Social Security Number. Failure to provide the Social Security Number will delay processing of your application.

6. Enter the city, state and zip code where services will be provided.

7. Enter the county for where services will be provided.

8. Enter the length of time you have lived at this residence.

9. This residence is the location where home care services will be provided. Enter your principal place of residence. Two proofs of residence must accompany this application. The proofs must be current and dated. The date must be clearly visible and be within the last six months.

   Some examples of evidence of residency are:
   - Motor Vehicle records (e.g., Valid Driver's License)
   - Social Security Form #2458 or Third Party Query Form
   - Landlord's records and rent receipts
   - Public utility record and receipts (e.g., electric bill, phone bill, etc.)
   - Personal property assessment records
   - Bills of business or professional people (e.g., doctors, department stores, etc.)
   - Post Office records.
   - Records of social agencies, public or private
   - Employment records

10. Enter telephone number, including area code.

11. Enter whether you have been tested positive for HIV and the month and year of the test. If you do not know the month and/or year, enter 99 for which you do not know (99/99 if both are unknown).

12. Enter whether you have been diagnosed with AIDS and the month and year of the test. If you do not know the month and/or year, enter 99 for which you do not know (99/99 if both are unknown).

13. Enter the date you completed the Application.

SECTION II – CURRENT INSURANCE COVERAGES/BENEFITS

14. Indicate whether you have applied for or are enrolled in Supplemental Security Income (SSI) benefits. If yes, provide the status and date of your application or your enrollment.

15. Indicate whether you have applied for or are enrolled in Social Security Disability (SSD) benefits. If yes, provide the status and date of your application or your enrollment.

16. Indicate whether you have applied for or are enrolled in the AIDS Community Care Alternatives Program (ACCAP). If yes, provide the status and date of your application or your enrollment, your ID Number, and whether the HIV Home Care Program will be supplementing ACCAP.

17. Indicate whether you have applied for or are enrolled in Jersey Care. If yes, provide the status and date of your application or your enrollment.

18. Indicate whether you have State Medicaid. If yes, provide your ID Number and Program Name and effective date.

19. Indicate whether you have Medicare A (Hospital Insurance). If yes, provide your ID Number and Program Name and effective date.

INSTRUCTIONS FOR COMPLETION OF THE APPLICATION FOR ELIGIBILITY FOR THE HIV HOME CARE PROGRAM (Continued)

20. Indicate whether you have Medicare B (Medical Insurance). If yes, provide your ID Number and Program Name and effective date.

21. If you have other health insurance coverage, the plan or company must be identified by name and address. If this coverage is provided by a current or previous employer or union, please enter that employer's or union's address. Indicate ID Number and Plan.

SECTION III – HOUSEHOLD/INCOME INFORMATION

Household is defined as a domestic establishment, which includes members of a family and/or other living under the same roof. The number of persons in a household includes: (1) those persons whose living situation is supported primarily by the individual making application to the program, (2) the parent or guardian in the case of an adolescent, and (3) other persons contributing to the primary support of the applicant.

Individuals applying to the HIV Home Care Program must have a monthly income in accordance with the standards listed below:

Number of Persons In Household	Annual Income Limit
1	$54,450
2	$73,550
3	$92,650
4	$111,750
5	$130,850

For each additional person in the household, add $19,100.

22. Indicate the number of persons living in the household, according to the above directions.

23. Indicate the exact amount of household gross monthly income from all sources in the 30 days preceding application. Income from the entire number of persons in the household must be indicated. Assets will not be considered a source of income. Sources of income include, but are not limited to; Social Security benefits (net), pension benefits, salary (before payroll deductions), unemployment benefits, interest and dividends, and rental income (net, after expenses).

24. Proof of monthly income in the 30 days preceding the date of application must be provided. Proof of income includes, but is not limited to; pay stubs, bank statements, and income tax returns.

25. Indicate Living Arrangement.

26. Provide list of household members.

27. Indicate current employment status.

SECTION IV – CERTIFICATION AND AUTHORIZATION

The Certification and Authorization must be dated and signed (or marked) by you and the preparer of the form (if other than the applicant) in the presence of a witness. 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.

The application will not be considered complete until submission of the required physician certification.

The Case Manager will review and update the most current information on the medical and financial status of the client every 30 days on a Monthly Eligibility Report.

A new Application for Eligibility will be completed on a yearly basis.

Retain these instructions. You have the right to appeal if you are determined to be ineligible for participation in this program.

All correspondence and/or inquires regarding rights of appeal should be directed to the HIV Home Care Program Coordinator at the following address and telephone number:

New Jersey Department of Health
Division of HIV, STD and TB Services
PO Box 363
Trenton, NJ 08625-0363

Telephone Number: 609-984-6328