

# Rhode Island AIDS Drug Assistance Program Enrollment Form

Do not write in this box →

Insurance

**Instructions:**

- You can enroll with a case manager at a RI Department of Health funded community-based organization to assist you with this application.
- Review *RI ADAP Client Agreement Statement*.
- Answer all the questions on the *Financial Enrollment Form* (pages 1-3).  
Both you and your case manager (if you have one) must sign and date this form.
- Ask your medical doctor to complete and sign the *Medical Enrollment Form* (page 4).
- Submit both forms at the same time (*Financial and Medical*) along with proof of income and residency and copies of any health coverage/insurance cards.

**Demographic Information**

Last Name	First Name	MI
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Street Address* (Mailing Address - Must be RI address)	City	Zip
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Telephone ( ) - -	Social Security # - -
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**Contacting You**

Yes     No    Can we leave confidential message at this phone number?

Yes     No    Would you prefer that future recertification applications be sent to your case manager?

Date of Birth ____/____/____	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender
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**Sexual Orientation**

Gay Man     Lesbian     Heterosexual     Bisexual     Other

**Marital Status (Relationship Status)**

Married     Domestic Partner     Single/Never Married     Divorced or Separated     Widowed

<b>Ethnicity (please check one)</b> <input type="checkbox"/> Hispanic/Latino(a) <input type="checkbox"/> Not Hispanic/Latino(a)	<b>Race</b> <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> More than one race
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Please also complete race →

Country of Birth _____	Preferred Spoken Language _____
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**HIV Transmission**

How did you contract HIV?     Male to male sex     Heterosexual sex     Other

IV drug use     Do not know

**\*Remember to attach Proof of RI residency. This can include a copy of a driver's license, utility bill, or rental agreement. The address on the document should match the address above. If no permanent residence, your case manager can provide a letter documenting your current address.**

**Case Manager**

Name	Organization
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Address	City, State, Zip
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Phone ( )	Fax ( )	E-Mail Address
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Case Manager's Signature \_\_\_\_\_ Date: \_\_\_\_\_

Additional Comment:

**Return this completed form by mail or fax to:**  
 RI Dept. of Health, Office of HIV/AIDS & Viral Hepatitis  
 3 Capitol Hill, Room 302  
 Providence, RI 02908

Tel: 401-222-4610  
 Fax: 401-222-7620  
[www.health.ri.gov](http://www.health.ri.gov)

**Financial Information****Your gross annual income\***

\$ \_\_\_\_\_

**Dependents**

\_\_\_\_\_ (#)

**Housing Status**

- Permanent (rent or own)
- Temporary (shelter, family/friends, facility)
- Homeless

**Total Liquid Assets\*\*(see definition and exclusions below)**

\$ \_\_\_\_\_

**Employment**Are you currently employed?  Yes  No

**\*Gross income means total income before taxes and deductions. Your income includes all earnings and support, including SSDI, SSI, unemployment compensation, and other benefits, as well as, income from a legal spouse. Remember to attach proof of income, such as a copy of your most recent pay stub (showing period covered by the check), or a tax return or W-2 form for the most recent tax year. If self-employed, include a copy of your most recent federal tax return or 1099 form. If you have no earnings, please include a letter from your case manager stating that you have no income and describing how you are being supported.**

**\*\*Liquid assets include any savings, checking, or money market accounts, stocks/bonds, investments, or other easily convertible assets EXCEPT for your primary residence and automobile.**

**Insurance/Health Care Coverage**

**Please indicate whether your health care is paid for by any of the following programs. If yes, provide your ID or Card # and/or name of insurer/carrier. If no, indicate if you have applied and when (if applicable).**

<b>Medicaid/Medical Assistance</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No ID/Card# _____ <input type="checkbox"/> Managed Care? <input type="checkbox"/> HMO?	If no, have you applied? <input type="checkbox"/> Yes <input type="checkbox"/> No Date applied: _____
<b>Medicare</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No ID/Card# _____	If no, have you applied? <input type="checkbox"/> Yes <input type="checkbox"/> No Date applied: _____
<b>Medicare Part D (Pharmacy Benefit)</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No ID/Card# _____ Plan Name: _____	If no, have you applied? <input type="checkbox"/> Yes <input type="checkbox"/> No Date applied: _____
<b>Rite Care</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No ID/Card# _____	If no, have you applied? <input type="checkbox"/> Yes <input type="checkbox"/> No Date applied: _____
<b>GPA</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No ID/Card# _____	If no, have you applied? <input type="checkbox"/> Yes <input type="checkbox"/> No Date applied: _____
<b>Private Insurance</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No ID/Card# _____ Insurers Name: _____	Does your prescription benefits require you to use a mail order pharmacy? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Veterans Administration (VA)</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No ID/Card# _____	If no, have you applied? <input type="checkbox"/> Yes <input type="checkbox"/> No Date applied: _____
<b>Other Public Assistance (specify) _____</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No ID/Card# _____	If no, have you applied? <input type="checkbox"/> Yes <input type="checkbox"/> No Date applied: _____

Is AIDS Project RI helping you with COBRA/Health Insurance payments?  Yes  No

**\*Remember to attach a copy of your insurance card for any of the programs above in which you participate. Insurance information and a copy of your card are REQUIRED for enrollment.**

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<b>Pharmacy*</b>		
<b>Store Name</b>	<b>Phone</b> (    )    -	<b>Do not write in this space</b> <input type="checkbox"/> Pharmacy contacted Date: _____
<b>Address</b>		

**\*Pharmacy information is REQUIRED. Without it, we cannot contact the pharmacy and enroll you in the program.**

**Would you be interested in participating in a Survey for ADAP**  Yes  No    **Focus Group for ADAP?**  Yes  No  
**If yes, which is the best way to contact you? (by phone please list phone number, by email please list email address)**  
Phone \_\_\_\_\_ email \_\_\_\_\_

**Client Certification and Signature**

I fully understand that by applying for this program, I am divulging personal information that will be used to assist the Rhode Island Department of Health in providing me with benefits associated with the RI AIDS Drug Assistance Program. I understand this information will be kept confidential, (§23-6-17 Confidentiality, §23-6-18 Protection of Records), but will be used by staff to review my eligibility for this program. Also, by signing this form, I understand that the information contained within may be used to verify HIV status, receive information from my physician about my care, or obtain other necessary information to provide me with these benefits. By applying for this program I fully understand that this does not mean that my application will be accepted, as funds are limited and eligibility requirements must be met. In addition, I understand Rhode Island Department of Health reserves the right to terminate benefits due to non-adherence to medication pick up, not recertifying every 6 months, a lack of funds and/or fraudulent claims on behalf of an applicant. I also understand that this program is a payer of last resort, meaning that I must exhaust all other possible sources of payment for these services before applying for this program. Lastly, I understand that it is my responsibility to provide Rhode Island Department of Health with truthful information and documentation about my financial, employment, insurance, and HIV status.

I certify that the information provided in this application is true and correct as of the date below and acknowledge that any intentional or negligent misrepresentation of the information may result in nullification of this application and liability for money granted.

- 1. It is my responsibility to re-apply (recertify) with ADAP every 6 months on or before my birth month and 6months following. If I do not recertify, my ADAP benefits will be terminated.**
- 2. It is my responsibility to pick up medications prescribed to me. I understand if I do not adhere to medication(s) prescribed, my ADAP benefits will be terminated.**

Lastly, I certify that I have received and agree to all the terms in the **RI ADAP Client Agreement Statement.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_

**Checklist**

**Please submit all required forms and documents at one time via fax or mail to the address at the bottom of the page. Incomplete applications will delay your enrollment and access to this program.**

**Did you remember to:**

- Attach proof of Rhode Island residency? (copy of lease, utility bill with address, driver's license, etc.)?
- Attach proof of income (e.g., copy of pay stub, assistance checks)?
- Include a completed Medical Enrollment Form (next page) signed by your provider/physician?
- Attach copy (-ies) of any health insurance or benefits cards?
- Include your case manager's signature on page 1?
- Sign the client agreement above?

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# Rhode Island AIDS Drug Assistance Program MEDICAL Enrollment Form

Do not write in this box →

Client Code

**Instructions**

- This form is to be completed by the client's Medical Provider.
- Please print clearly and provide all requested information.
- Sign form and return to client.
- Client – Return this form together with the Financial Enrollment Form and all required documentation.

**Client Name**

**Date of Birth**

Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
month day year

**HIV** Date  
Approximate date of first positive HIV test: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
month day year

**AIDS Diagnosis** Date  
 Yes  No If yes, date of diagnosis: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
month day year

**HCV Test** Date **HCV Diagnosis (if tested)**  
 Yes  No If yes, date of test: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
month day year  Negative  Positive

**General HIV Medical Care Visit Previous 6 months** **Date of Last General HIV Medical Care Visit**  
 Yes  No Date of last test: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(please provide date for both Yes or No response) month day year

**CD4 Count** **Date of Last CD4 Test** **NADIR Count** **Date of NADIR**  
Count: \_\_\_\_\_ \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
month day year Count: \_\_\_\_\_ \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
month day year

**Viral Load (Most Recent)** **Date of Last Viral Load Test** **Test Type (bDNA, RT-PCR)**  
Load: \_\_\_\_\_ \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
month day year

**Drug Therapy: Have you ordered medications on the ADAP formulary for this client?**  Yes  No  
If Yes, which medication(s) were prescribed: \_\_\_\_\_

Has the patient committed his/her self to take medication(s)?  Yes  No  
 No HAART medications  \_\_\_\_\_ (#) Antiretrovirals  HCV Therapy

**Name of Physician (print)** \_\_\_\_\_ **RI Lic.#** \_\_\_\_\_  
**Clinic Name:** \_\_\_\_\_  
**Signature of Physician** \_\_\_\_\_ **Date** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

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# Rhode Island AIDS Drug Assistance Program Client Agreement Statement

The following are guidelines that must be followed for you to receive drug coverage through the Rhode Island AIDS Drug Assistance Program (ADAP). The RI ADAP will keep your information strictly confidential (§23-6-17 Confidentiality, §23-6-18 Protection of Records). If you do not follow these guidelines, if you provide false information, or if we suspect you are using funds for ADAP to which you are not entitled, you may be terminated from RI ADAP.

**By participating in ADAP, I agree to the following:**

**1. I give permission to the RI ADAP staff (coordinator, program manager, eligibility technician, administrator) to contact:**

- a. My pharmacist
- b. My case manager
- c. My employer (for employee contributions to COBRA)
- d. My current or past health care provider(s)
- e. Any other person that I have specifically given permission to contact.

If needed, RI ADAP may contact these people to maintain my participation in the program. RI ADAP staff may also contact any insurance companies (third party payers/administrators) to make sure I am covered and to answer any billing questions. RI ADAP may also contact any of the people in the above list when I leave the program, if necessary. This may be done to get information about my participation in the program.

**2. I give permission for my ADAP enrollment application files to be reviewed by the following:**

- a. HEALTH staff
- b. My case manager and/or health care provider
- c. Auditors or other individuals reviewing application files as required for program fiscal monitoring.

Information in your ADAP enrollment application files will be kept strictly confidential. Under no circumstances will any personal identifying information in my ADAP file be shared with any unauthorized individual.

**3. I agree to notify HEALTH as soon as possible if any of this information changes. I need to report any other information that might change my eligibility for programs, including but not limited to:**

- a. Employment status
- b. Income
- c. Residence and Mailing address if separate
- d. Access to insurance coverage/Medicaid status
- e. Citizenship status

**4. My application may be rejected if I have provided false information.**

**5. ADAP cannot provide payments or reimbursements directly to me for any reason.**

**6. I may be required to pay back any ADAP benefits received if I was not eligible for them.**

**7. ADAP is not required to make retroactive payments for coverage before I was enrolled in the program or if my enrollment lapses.**

**8. It is my responsibility to re-apply (recertify) with ADAP every 6 months on or before my birth month and 6 months following. If I do not recertify, my ADAP benefits will be terminated.**

**9. It is my responsibility to pick up medications prescribed to me. I understand if I do not adhere to medication(s) prescribed, my ADAP benefits will be terminated.**