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 or 1-800-353-3232 for HICP.

SECTION I - APPLICANT INFORMATION

Enter your principal place of residence. Seasonal or temporary residence in New Jersey, of whatever duration, does not constitute residency. The residency requirement states that you must be a resident of New Jersey for at least 30 days prior to the date of this application.

Include two (2) proofs of residency which are current and dated. The date must be clearly visible and no more than six (6) months old. Sample proofs of residency include:

- Motor Vehicle records (e.g., valid Driver's License)
- Landlord's records and rent receipts
- Public utility records and receipts (electric, gas, phone bill)
- Bills of business or professional people (doctors, department stores)
- Records of social agencies, public or private
- Personal property assessment records
- Employment records
- Social Security records
- Post Office records

Include proof of citizenship or, if a legal alien, include a copy of your Alien Registration Card. Some examples of proof of citizenship include:

- Birth Certificate
- Passport
- Voter Registration Card

You are not required to submit your Social Security number to apply for ADDP; however, failure to provide one may delay the processing of your application. Your Social Security number 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. **NOTE: For HICP, providing your Social Security Number is mandatory.**

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; OR
(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, contact ADDP at 1-877-613-4533 for an Affidavit of Separation form.

HOUSEHOLD SIZE:
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.

FAMILY SIZE:
Family is defined as anyone who is related to you, the applicant, by blood, marriage or adoption. To calculate your 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

Enter your **TOTAL HOUSEHOLD INCOME**, by category, for last year and for this year. 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 which must be included under "Additional Income" are:

- Retirement Benefits/Annuities
- Palimony/Alimony Payments
- Disability Benefits
- Business Income (Net)
- Realized Capital Gains
- Death Benefits Received (Net)
- Inheritance
- Royalties

Maximum Allowable Household Income Limits for this ADDP and HICP as of January 24, 2013 are listed below.

Income limits are updated in March each year in accordance with federal poverty guidelines. If you need current income limits, call 1-877-613-4533.

Number of Persons in Household	Maximum Allowable Household Income
1	$57,450
2	$77,550
3	$97,650
4	$117,750
5	$137,850

For households with more than 5 persons, add $20,100 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 IV - 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 V - 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, who is aware of your HIV status and your circumstances, in the event that you are unavailable and we need information regarding your participation in ADDP and/or HICP.

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:
Complete the case manager information if applicable.

CERTIFICATION BY PHYSICIAN (Form DHAS-40)

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.

HEALTH INSURANCE INFORMATION FORM (DHAS-39) *(ONLY IF APPLYING FOR HICP)*

Questions 1 through 6: Answer 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.

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
- ☐ Documentation of U.S. citizenship or if you are a legal alien, a copy of your Alien Registration Card
- ☐ Verification of income (current paystubs, 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, forward a copy of your Notification of Social Security Disability Entitlement.
- ☐ Copies of the FRONT and BACK of all health insurance/prescription cards
- ☐ Certification by Physician form (DHAS-38) (completed and signed)
- ☐ Certification by Pharmacist form (DHAS-40) (completed and signed) (only for ADDP)

If applying for HICP, also include:

- ☐ Original premium notice with premium identification
- ☐ Health Insurance Information form (DHAS-39) (completed and signed)

Mail the completed application to:

ADDP
PO Box 722
Trenton, NJ 08625-0722

Or fax to: 609-588-7037 (for ADDP)
609-984-6495 (for HICP)

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

New Jersey Department of Health
AIDS Drug Distribution Program (ADDP)
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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. Mail the completed application to the ADDP Program at the address given above or fax it to 609-588-7037; for help with HICP call 1-800-353-3232 or fax to 609-984-6495. Send copies of any requested documents. Do NOT send original documents as they WILL NOT be returned.

I AM APPLYING FOR: ☐ **ADDP ONLY** ☐ **HICP* ONLY** ☐ **BOTH ADDP AND HICP***

*** IMPORTANT NOTICE: If you DO NOT currently have health insurance, you are not eligible to participate in 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. Residency
a. How long have you lived at the above address? ____ Years ____ Months
b. Is this your principal place of residence? ☐ Yes ☐ No

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

6. Immigration Status
a. Are you a U.S. citizen? ☐ Yes ☐ No **If yes, attach proof of citizenship (birth certificate, passport, voter registration)**
b. Are you a legal alien? ☐ Yes ☐ No **If yes, attach a copy of Alien Registration Card.**

7. Domestic Status	8. Gender	9. Race	10. Ethnicity
☐ Single ☐ Married ☐ Civil Union ☐ Divorced ☐ Widowed ☐ Separated* (*See Instructions)*	☐ Male ☐ Female ☐ Transgendered M to F ☐ Transgendered F to M	☐ White ☐ Black ☐ Asian ☐ American Indian/Alaskan Native ☐ Native Hawaiian/Pacific Islander ☐ Other: _____ ☐ Hispanic	☐ Hispanic/Latino ☐ Non-Hispanic ☐ Unknown

11. Has your domestic status changed in the last year?
☐ Yes ☐ No If yes, list date: ____ / ____ / ____
Month / Day / Year

12a. Applicant's Social Security Number	b. Spouse's/Partner's Social Security Number
___ ___ ___ - ___ ___ - ___ ___ ___ ___	___ ___ ___ - ___ ___ - ___ ___ ___ ___

13. Name of Spouse/Partner
Last: _____ First: _____

14. Female Applicants Only:
Have you been pregnant in the past 6 months? ☐ Not Applicable ☐ Yes ☐ No

15. What is the size of your household? _____ *NOTE: See Instructions for definitions of "household" and "family."*
16. How many family members live in your household? _____
17. List the names of all persons living in your household and identify their relationship to you:

Name _____ Relationship to Applicant _____
Name _____ Relationship to Applicant _____
Name _____ Relationship to Applicant _____
Name _____ Relationship to Applicant _____
Name _____ Relationship to Applicant _____
Name _____ Relationship to Applicant _____

List any additional people who reside with you but are not related to you.

Name _____ Name _____

If more space is needed, attach an additional sheet.

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(Continued)

SECTION II - HOUSEHOLD INCOME

18. Household Income

In Column A, enter your ACTUAL HOUSEHOLD income, from all sources, for last year. In Column B, enter what you EXPECT your HOUSEHOLD income will be, from all sources, for the current year. If your income from any of the sources listed below was "0" last year or is expected to be "0" this year, enter "0" in that column. Enter whole dollar amounts ($); do not list cents (¢). DO NOT LEAVE ANY BLANK SPACES! Submit official documentation to verify all income.

SOURCES OF INCOME ***Attach an additional sheet, if necessary.***	**COLUMN A** **20 _____** **Last Year Annual Income**		**COLUMN B** **20 _____** **Current Year Annual Income**		**COLUMN C FOR STATE USE ONLY DO NOT WRITE BELOW.**	
	(1) Applicant and Spouse/Partner	**(2) Others**	**(1) Applicant and Spouse/Partner**	**(2) Others**	**A / S/P**	**O**
Salary (Before Payroll Deductions)						
Unemployment Benefits						
Social Security Benefits (Net)						
Medicare Part B Annual Premium						
Pension Benefits (Identify in Section III below)						
Interest/Dividends						
Net Rental Income (after expenses)						
Other Income (Specify):						
TOTAL ANNUAL INCOME (FOR EACH COLUMN)						

Remember to submit official documentation to verify all income.

19. 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.

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

Applied For	**Receiving**	
☐	☐	AFDC
☐	☐	Food Stamps
☐	☐	Housing Assistance
☐	☐	Welfare
☐	☐	Medicaid
☐	☐	Social Security Insurance
☐	☐	Social Security Disability Insurance *(See Instructions)*
☐	☐	Supplemental Security Income (SSI)
☐	☐	Unemployment Compensation
☐	☐	Worker's Compensation

SECTION III - EMPLOYMENT STATUS

21. What is your current employment status?

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

Are you medically UNABLE to work? ☐ Yes ☐ No

22. Do you and/or your spouse/partner receive a salary or pension?

☐ Yes ☐ No

If Yes, provide the following information:

Name of Company, Employer or Union _____

Address of Above _____

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(Continued)

SECTION IV - INSURANCE COVERAGE

23. What type(s) of Health Insurance/Prescription Coverage do you have? *(Check ALL that apply)*

☐ Private Insurance *(If checked, complete Questions 24 and 25, Private Health Insurance and Prescription Coverage, below.)*

☐ Medicare Part A (Hospital Insurance) Medicare Claim Number: _____ Effective Date: _____

☐ Medicare Part B (Medical Insurance) Medicare Claim Number: _____ Effective Date: _____

☐ Medicare Part D (Prescription Insurance) ID Number: _____ Group Number: _____

Name of Company: _____

☐ Medicare HMO (Medicare Advantage) Name of HMO: _____

☐ Medicaid Medicaid No.: _____

☐ Municipal Welfare

☐ No Health Insurance/Prescription Coverage

FOR STATE USE ONLY

EMP CD	
INS CD	
SCOPE CD	

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): _____

24. Private Health Insurance *

Insurance Carrier: _____

Address: _____

_____

Telephone Number: _____

Policy Number: _____

If provided by Union or employer:

Employer/Union Name: _____

Address: _____

_____

25. 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: ( ) _____

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

b. Are you currently receiving prescription drug benefits under the Family Care Program? ☐ 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.

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SECTION V - 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.**

27. Signature of Applicant	Date
28. Signature of Spouse/Partner	Date

29. Applicant's Telephone Numbers:

Home: _____ Work: _____

Cell: _____ Pager: _____

Optional: Applicant's Email Address: _____ @ _____

Please be aware that we may use the email account you provide to send electronic mail to you with reminders of when you need to review your eligibility, to request additional information related to your application or other important notices regarding your participation in ADDP/HICP. Please be certain to give an email address where your confidentiality is secure.

30. Contact Person:

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 who is aware of your HIV status and your circumstances (preferably someone NOT living with you).

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

Email Address

Optional: Contact Person's Email Address: _____ @ _____

Please be aware that we may use the email account you provide to send electronic mail to you with reminders of when you need to review your eligibility, to request additional information related to your application or other important notices regarding your participation in ADDP/HICP. Please be certain to give an email address where the applicant's confidentiality is secure.

31. 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

32. Case Manager Information

Fill out this section ONLY if he/she provided assistance in completing this application.

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

Email Address

Case Manager's Email Address: _____ @ _____