

APPLICATION FOR THE HEALTH INSURANCE CONTINUATION PROGRAM

I. PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL	MAIDEN
ADDRESS	CITY AND STATE	ZIP CODE	
MAILING ADDRESS	CITY AND STATE	ZIP CODE	
DATE OF BIRTH ____/____/____	SOCIAL SECURITY # -- --	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> TRANSGENDER <input type="checkbox"/> UNKNOWN	TELEPHONE NUMBER #1 () - #2 () -
ETHNICITY <input type="checkbox"/> HISPANIC <input type="checkbox"/> NON-HISPANIC <input type="checkbox"/> UNKNOWN	RACE <input type="checkbox"/> WHITE OR CAUCASIAN <input type="checkbox"/> BLACK OR AFRICAN AMERICAN <input type="checkbox"/> ASIAN <input type="checkbox"/> AMERICAN INDIAN/ALASKA NATIVE <input type="checkbox"/> NATIVE HAWAIIAN or Other PACIFIC ISLANDER <input type="checkbox"/> OTHER <input type="checkbox"/> UNKNOWN	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED	

CLIENT STATUS?
 NEW
 TRANSFER FROM: _____

II. CLINICAL INFORMATION

<p style="text-align: center;">DIAGNOSIS</p> <input type="checkbox"/> AIDS DATE: ____/____/____ <input type="checkbox"/> HIV POSITIVE DATE: ____/____/____	<p style="text-align: center;">CD4</p> CURRENT: _____ DATE: ____/____/____ LOWEST: _____ DATE: ____/____/____
	<p style="text-align: center;">VIRAL LOAD</p> CURRENT: _____ DATE: ____/____/____ HIGHEST: _____ DATE: ____/____/____ CASE REPORT DATE: _____

PHYSICIAN INFORMATION

NAME _____

CLINIC NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____ () -

SIGNATURE _____ PHONE _____

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III. FINANCIAL INFORMATION

FAMILY SIZE				
NAME	RELATIONSHIP TO CLIENT	AGE	GROSS MONTHLY INCOME	SOURCE OF INCOME
APPLICANT	SELF			
		TOTAL	\$	
		TOTAL X 12 MONTHS =	\$	/ YEAR

ASSETS	
TYPE	AMOUNT
CASH ON HAND	\$
CHECKING ACCOUNT	\$
SAVINGS ACCOUNT	\$
STOCKS	\$
BONDS	\$
SEVERENCE PAY	\$
OTHER	\$
TOTAL	\$

NOTE: Total assets cannot exceed \$ 4,500 (\$5,500 if married)

INSURANCE INFORMATION	
<input type="checkbox"/> MEDICAID <input type="checkbox"/> MEDICAID SPENDDOWN (QMB)	MEDICAID #:
<input type="checkbox"/> MEDICARE <input type="checkbox"/> PART A <input type="checkbox"/> PART B <input type="checkbox"/> PART D	MEDICARE #: Applied for Low Income Subsidy (LIS) "extra help": yes <input type="checkbox"/> no <input type="checkbox"/> Approved for Full Low Income Subsidy (LIS) "extra help" yes <input type="checkbox"/> no <input type="checkbox"/> Approved for Partial Low Income Subsidy (LIS) "extra help" yes <input type="checkbox"/> no <input type="checkbox"/> MEDICARE Part D Plan Company Name: _____ Deductible \$ _____ Co-pays \$ _____ Premiums \$ _____
<input type="checkbox"/> VETERANS BENEFITS	
<input type="checkbox"/> PRIVATE HEALTH INSURANCE <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> GROUP <input type="checkbox"/> COBRA INCLUDES DRUG COVERAGE <input type="checkbox"/> YES <input type="checkbox"/> NO	INSURANCE COMPANY: POLICY #: PHONE NUMBER OF INSURANCE COMPANY: () -
<input type="checkbox"/> NO INSURANCE	CONTACT PERSON:

**APPLICATION FOR
THE HEALTH INSURANCE CONTINUATION PROGRAM**

IV. INSURANCE INFORMATION

We need this information to pay your premiums.

You must submit a copy of your most recent premium bill or payment coupons.

Insurance Company:	
Plan Name:	
Mailing Address (for premium remittance):	
City:	State:
Zip Code:	
Telephone Number:	

What type of coverage is this?

COBRA Individual Group Other: _____

If COBRA, when is the effective date? _____

NOTE: If this is a COBRA policy, when the policy coverage ends, you must try to get a conversion policy.

What is your:

Monthly Premium Rate/Amount: \$ _____

Policy Number: _____

Due Date of Next Premium: _____

Who are the premium checks made out to? _____

APPLICATION FOR THE HEALTH INSURANCE CONTINUATION PROGRAM

I attest that all of the information contained in this application is complete and accurate to the best of my knowledge.

Print Case Manager Name

Date

Case Manager Signature

() -

Case Manager Phone Number

COMMENTS: _____

() -

Case Manager Fax Number

FOR DHR USE ONLY	
	DISPOSITION OF APPLICATION
DATE RECEIVED	<input type="checkbox"/> NO PROOF OF HIV+ STATUS <input type="checkbox"/> INCOME EXCEEDS CURRENT CRITERION <input type="checkbox"/> NO PROOF OF GEORGIA RESIDENCY <input type="checkbox"/> CLIENT HAS INSURANCE (WITH RX COVERAGE) <input type="checkbox"/> CLIENT HAS VA BENEFITS <input type="checkbox"/> CLIENT HAS OTHER PAYOR SOURCE _____ <input type="checkbox"/> CLIENT EXCEEDS MEDICAL ELIGIBILITY CRITERION <input type="checkbox"/> INCOMPLETE APPLICATION* <input type="checkbox"/> WAITING LIST PRIORITY LEVEL: _____ <input type="checkbox"/> APPROVED <input type="checkbox"/> NOT APPROVED
	_____ REVIEWED BY
	_____/_____/_____ *DATE RETURNED TO ENROLLING AGENCY