

NEW ENROLLMENT APPLICATION
2008/2009 CO-PAYMENT AND DEDUCTIBLE ASSISTANCE PROGRAM

HAART
 ATTN: CDAP
 P O BOX 66913
 BATON ROUGE LA 70896-6913

****Assurance of confidentiality****

All information that you provide as part of this application will be kept strictly confidential to the fullest extent allowable by the law. The information collected and the reported of this project will be in aggregate form only and the identity of any applicants and/or participants will not be revealed under any circumstances, except as necessary to carry out the activities of the program.

REGION: (CIRCLE) 1 2 3 4 5 6 7 8 9 CDAP FILE # _____

Agency: _____ Case Manager _____ Phone _____

Client Information

1. Name (Last, First, MI)

2. Home Address (street, city, state, zip code)

Can mail be sent to this address? ____yes ____no

Can we contact you by phone? ____yes ____no

Home/Cell Phone Number () /

3. Date of Birth

____/____/____

4. Parish of Residence

5. Phone Number

Home () _____-_____

Work () _____-_____

6. Gender

____Male

____Female

____Transgender

7. Social Security Number

____/____/____

8. Ethnicity

____White ____Hispanic

____Black ____Non-Hispanic

____Asian ____American

____Other ____Indian

INCOME AND ASSETS

A household is defined as ALL members related by blood or marriage residing in the same dwelling. If you are claimed as a dependent for income tax purposes provide proof of income of the person claiming you. If your income from any source is '0', enter '0' in the space provided. DO NOT LEAVE ANY BLANKS! You must provide verification of all sources of income and assets (copies of most recent pay stubs, SSD awards letter, 2 current bank statements, etc). If no income, please provide a notarized "0" income state

9. HOUSEHOLD INCOME PER MONTH:

\$ _____ Salary/Wages

\$ _____ SSI/SSD/Social Security*

\$ _____ Alimony / Child Support

\$ _____ Unemployment

\$ _____ Workers' Compensation

\$ _____ Pension / Private Disability

\$ _____ Interest / Dividend Income

\$ _____ Other (specify) _____

\$ _____ TOTAL per month

* I began receiving SSI/SSD payments on ____/____/____

10. AMOUNT CASH ASSETS:

\$ _____ Savings Account

\$ _____ Checking Account

\$ _____ IRA Account

\$ _____ Money Market Account

\$ _____ Certificate Of Deposit

\$ _____ Pension &/ Private

\$ _____ Additional Residences/ Real Property

\$ _____ Other (Specify) _____

\$ _____ TOTAL

Medical Providers

List the names and addresses of the medical providers which you regularly visit and require assistance with co-payments and deductibles.

Name, Address and Phone# of Medical Provider

Account # _____	Contact Person _____
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Name, Address and Phone# of Medical Provider

Account # _____	Contact Person _____
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Name, Address and Phone# of Medical Provider

Account # _____	Contact Person _____
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INSURANCE INFORMATION

List the names and addresses of each insurance company for in which you may require assistance with paying co-payments or deductibles. This includes medical, dental and vision insurance policies.
Identify each type of insurance company listed as follows: Private policy, COBRA, Group policy (through employer), Medicare Supplemental, High Risk Insurance Pool, Other

Name, Address and Phone # of Insurance Company

Policy # _____	Type of Insurance _____
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Date Deductible Begins _____/_____/_____	Amount of Deductible \$ _____	Amount Paid Year to Date \$ _____
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Amount of Office Visit Co-Payment \$ _____	Amount of Prescription Co-payment \$ _____
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Name, Address and Phone # of Insurance Company

Policy # _____	Type of Insurance _____
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Date Deductible Begins _____/_____/_____	Amount of Deductible \$ _____	Amount Paid Year to Date \$ _____
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Amount of Office Visit Co-Payment \$ _____	Amount of Prescription Co-payment \$ _____
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Name, Address and Phone # of Insurance Company

Policy # _____	Type of Insurance _____
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Date Deductible Begins _____/_____/_____	Amount of Deductible \$ _____	Amount Paid Year to Date \$ _____
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Amount of Office Visit Co-Payment \$ _____	Amount of Prescription Co-payment \$ _____
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11. Employment Status
<input type="checkbox"/> Full Time <input type="checkbox"/> Part-time <input type="checkbox"/> Not Employed

Current Employer (Include contact person, phone number and fax number)

ADDITIONAL REQUIRED INFORMATION

12. ARRANGEMENTS: <input type="checkbox"/> Live alone <input type="checkbox"/> Live w/ Parent or Guardian <input type="checkbox"/> Live w/ spouse or significant other	TOTAL Household # ____ <input type="checkbox"/> Live w/ relatives other than spouse <input type="checkbox"/> Live w/ children or parents who receive assistance from client	<input type="checkbox"/> Live w/ non relatives who share expenses <input type="checkbox"/> Live in residential facility <input type="checkbox"/> Live in homeless care facility
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13. TYPE OF DWELLING: <input type="checkbox"/> House <input type="checkbox"/> Apartment <input type="checkbox"/> Mobile <input type="checkbox"/> Residential Facility <input type="checkbox"/> Shelter/Homeless	14. Educational Level <input type="checkbox"/> K-8 <input type="checkbox"/> Some College <input type="checkbox"/> 9 th (no degree) <input type="checkbox"/> 10 th <input type="checkbox"/> College Degree <input type="checkbox"/> 11 th <input type="checkbox"/> Graduate Degree <input type="checkbox"/> 12 th	15. Previously incarcerated within the last 6 months? <input type="checkbox"/> yes <input type="checkbox"/> no
		16. Veteran Status: <input type="checkbox"/> Yes <input type="checkbox"/> No

16. I am currently enrolled in the :
 Health Insurance Continuation Program
 AIDS Drug Assistance Program

Signature

a. I declare that all statements made on this data collection form are true and complete to the best of my knowledge. I realize that willful falsification of this information by me will subject me to immediate disqualification from participation in the Co-payment and Deductible Assistance Program.

b. I also understand that if I qualify for participation, CDAP agrees to pay for co-payments and deductibles. CDAP will assist with the expenses of co-payments and deductibles, for me as long as funds are available and this program is in existence.

c. I understand that it is my responsibility to supply the community based organization or CDAP directly with any information related to my co-payment and/or deductible.

d. Furthermore, it is my responsibility to report any changes in my income and/or cash assets.

e. Finally, I will apply for all assistance for which I may be eligible, including, but not limited to Social Security benefits.

APPLICANT SIGNATURE	DATE
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