For LA HAP Staff Use Only

Reviewer's Initials _____ Data Entry's Initials _____

Date Complete Application Received: _____ Date of Application Determination: _____

Application Type: New Enrollment / Recertification / Returning Application Determination: Approved / Denied

LOUISIANA HEALTH ACCESS PROGRAM (LA HAP) APPLICATION

Please print clearly. If you need assistance completing this application, please contact LA HAP at 504-568-7474. The application may be mailed to 1450 Poydras St, Suite 2136, New Orleans, LA 70112 or faxed to 504-568-3157. Remember to include all required documents.

Submission of an incomplete application or failure to submit required income documentation will result in your application being delayed and could result in your application being denied.
If approved, federal legislation requires LA HAP to review client eligibility twice a year.

SECTION 1: ASSISTER INFORMATION

1. Is anyone helping you complete this application? ☐ Yes ☐ No. **Skip** to SECTION 2.

2. Tell us if you're getting help from one of these people: **Check all that apply**

☐ HIV-related case manager or social worker ☐ Non-HIV-related case manager or social worker ☐ LA HAP Staff

☐ Hospital or Medical Clinic Staff ☐ Friend ☐ Family ☐ Other, specify: _____

SECTION 2: CONTACT INFORMATION

1. First Name	2. Middle Initial	3. Last Name and Suffix	4. Maiden Name (if applicable)

5. Have you had a name change within the last 12 months? ☐ Yes ☐ No. **Skip** to question 7.

6. What was your former or old name? (first and last name)

7. Date of Birth (MM/DD/YYYY)

8. Social Security Number (SSN) ☐ I do not have a SSN

9. Language Preference (if not English)

10. Are you currently homeless? **(residential address and mailing address still required)** ☐ Yes ☐ No

11. Residential Address (where you sleep; no PO Boxes) ***REQUIRED***

12. Apartment/Unit #

13. City

14. State

15. ZIP Code

16. Do you want mail, **including your LA HAP card**, sent to your residential address? ☐ Yes. Send mail and my card to my residential address. **Skip** to question 22. ☐ No. Do NOT send mail or my card to my residential address. **Fill** in your mailing address in question 17.

17. Mailing Address (if different than residential address; can use provider's address) ***REQUIRED***

18. Apartment/Unit #

19. City

20. State

21. ZIP Code

22. Primary Phone ☐ No primary phone

(_____)_____-_____

May LA HAP contact you at this number? ☐ Yes ☐ No

May LA HAP leave a voicemail at this number? ☐ Yes ☐ No

May LA HAP text you at this number? ☐ Yes ☐ No

23. Secondary Phone ☐ No secondary phone

(_____)_____-_____

May LA HAP contact you at this number? ☐ Yes ☐ No

May LA HAP leave a voicemail at this number? ☐ Yes ☐ No

May LA HAP text you at this number? ☐ Yes ☐ No

24. Email address (optional)

May LA HAP contact you at this address? ☐ Yes ☐ No

Would you like to receive important updates about LA HAP at this address? ☐ Yes ☐ No

25. Do you have a friend or family member (alternate contact) that LA HAP may speak to about your application on your behalf?

☐ Yes. **Fill** in your alternate contact's information in questions 26-28. ☐ No. **Skip** to SECTION 3.

26. Alternate Contact's Name	27. Relationship to you	28. Phone Number

First Name:	Last Name:

SECTION 3: DEMOGRAPHIC INFORMATION

1. Gender: ☐ Male ☐ Female ☐ Transgender (Male to Female) ☐ Transgender (Female to Male)

2. Race:

☐ American Indian or Alaska Native ☐ Asian. **Fill** in 2a below. ☐ Black / African American ☐ Native Hawaiian or Pacific Islander. **Fill** in 2b below. ☐ White / Caucasian ☐ Other

*2a. If you answered "**Asian**," how do you identify?* ***Check all that apply.***

☐ Asian Indian ☐ Chinese ☐ Filipina/o ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian

*2b. If you answered "**Native Hawaiian or Pacific Islander**," how do you identify?* ***Check all that apply.***

☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander

3. Ethnicity:

☐ Hispanic or Latina/o. **Fill** in 3a below. ☐ Non-Hispanic

*3a. If you answered "**Hispanic or Latina/o**," how do you identify?* ***Check all that apply.***

☐ Mexican, Mexican-American, or Chicana/o ☐ Puerto Rican ☐ Cuban ☐ Other Hispanic, Latina/o or Spanish origin

4. Relationship Status: **("Partnered" can be checked in addition to "Divorced" <u>or</u> "Widowed," if applicable.)**

☐ Single: *never married and not living with girlfriends, boyfriends, partners, or significant others*

☐ Married and living with spouse: *legally married, spouse is in the same house*

☐ Married and not living with spouse: *legally married, spouse is NOT in the same house*

☐ Divorced: *was legally married but is no longer legally married*

☐ Partnered: *not legally married and living with girlfriends, boyfriends, partners, or significant others*

☐ Widowed: *was legally married but spouse became deceased and surviving spouse has not legally remarried*

SECTION 4: HOUSEHOLD INFORMATION

1. What is your tax filing status?

☐ Single ☐ Married, filing jointly ☐ Married, filing separately ☐ Head of household

☐ Someone else claims me as a dependent on their tax return *Who claims you as a dependent?* _____

☐ I don't file taxes because I'm not required to and no one claims me as a dependent

☐ I don't file taxes for another reason and no one claims me as a dependent. **Fill** in 1a below. *(this won't affect your eligibility)*

*1a. If you answered **"I don't file taxes for another reason,"** what is the reason? (this won't affect your eligibility)*

_____

2. List the relationship and age of member of your household below, besides yourself. **Follow these rules for household**:

- **If you file taxes**, your household members are your spouse and anyone you claim as a dependent on your tax return.
- **If you do NOT file taxes but SOMEONE CLAIMS YOU as a dependent on their tax return,** your household members are your spouse, the person(s) who claim you as a dependent, their spouse, and any other dependents they claim.
- **If you do NOT file taxes and NO ONE CLAIMS YOU as a dependent on their tax return,** your household members are: your spouse and your natural/legal/adopted children or stepchildren living in the same house as you, **AND** (if you are 18 or younger) your natural/adopted/stepparents and any natural/adopted/stepsiblings 18 or younger

Relationship to you	Age	Does this person receive income?
a)		☐ Yes ☐ No
b)		☐ Yes ☐ No
c)		☐ Yes ☐ No
d)		☐ Yes ☐ No
e)		☐ Yes ☐ No

3. Is there anything else you would like to tell us about your living situation that could help clarify your application (for example: you live with one parent but are claimed on your other parent's taxes)?

First Name:	Last Name:

SECTION 5: EMPLOYMENT INFORMATION

1. What is your current employment status? **Check only one**

☐ Employed – Full time ☐ Employed – Part time ☐ Employed – Seasonal/Temporary

☐ Unemployed. **Skip** to SECTION 6. ☐ Retired. **Skip** to SECTION 6. ☐ Medically Unable to Work. **Skip** to SECTION 6.

2. What is your employer's name? **If you have more than one employer, list all employers' names.** (We will **not** contact your employer)

3. How often are you paid? ☐ Once a week ☐ Every 2 weeks ☐ Once a month ☐ Other, specify:_____

SECTION 6: HOUSEHOLD INCOME INFORMATION

Check each type of INCOME that you and others in your household receive and any DEDUCTIONS claimed on a tax return. DOCUMENTATION OF EACH TYPE OF INCOME RECEIVED OR DEDUCTIONS CLAIMED BY YOUR HOUSEHOLD MUST BE ATTACHED TO YOUR APPLICATION. For acceptable forms of documentation, visit www.lahap.org or call LA HAP.

Income Source	I receive this.	Someone in my household receives this.	Proof attached to application?
No Income/deductions of any kind *(documentation only required for applicant)*	☐	☐	☐
Salary/Wages/Commission/Tips	☐	☐	☐
Self-Employment Income	☐	☐	☐
Any foreign earnings	☐	☐	☐
Any non-taxable interest	☐	☐	☐
Unemployment benefits	☐	☐	☐
Pensions	☐	☐	☐
Social Security (Retirement/Survivor's/Disability) **If receiving SSDI, indicate start date: _____/_____/_____**	☐	☐	☐
Retirement accounts	☐	☐	☐
Alimony received	☐	☐	☐
Net farming/fishing	☐	☐	☐
Net rental/royalty	☐	☐	☐
Net capital gain	☐	☐	☐
Scholarships/Grants	☐	☐	☐
Supplemental Security Income, Child Support, Veterans' Payments, or TANF/SNAP	☐	☐	Not required
Other Income (specify type):	☐	☐	☐
Other Income (specify type):	☐	☐	☐
Deduction: Student loan interest paid	☐	☐	☐
Deduction: Alimony paid	☐	☐	☐
Other deduction (specify type)**:**	☐	☐	☐
Total Annual Household Income **(LA HAP staff use only)**			

2. Is there anything else you would like to tell us about your household income that could help clarify your application (for example: your tax return from last year doesn't reflect this year's income)?

First Name:	Last Name:

SECTION 7: ASSISTANCE INFORMATION

1. Do you have any insurance? **Check all that apply.**

☐ No. I have no insurance and I am requesting LA HAP assistance with medications only. **Skip** to SECTION 14.

☐ Yes. I have Medicare Part A, B, C, and/or D, and/or Medicare Supplement. **Fill** in the information in SECTION 8.

☐ Yes. I have one or more health insurance policies that are not Medicare (ex: marketplace; employer sponsored insurance; COBRA). **Fill** in the information in SECTION 10.

☐ Yes. I have dental and/or vision insurance coverage that is not included in a health or Medicare policy. **Fill** in the information in SECTION 12. *If this is the only insurance you have, you will also be automatically considered for medication assistance.*

SECTION 8: MEDICARE INSURANCE POLICY INFORMATION

You may submit this form without the Member ID/Policy # and Group #. However, the Member ID/Policy # and Group # (if applicable) **must be submitted to LA HAP within 2 months of the policy start date** to continue LA HAP insurance assistance.

1. What type of Medicare do you have? **(Check all that apply)**

☐ Medicare Part A and B ☐ Medicare Part A ONLY (no Part B) ☐ Medicare Part B ONLY (no Part A)

☐ Medicare Part C (Advantage) ☐ Medicare Part D ☐ Medicare Supplement (Medigap)

2. What is your current Low-Income Subsidy (LIS) status?

☐ Approved-currently receiving LIS. *LA HAP may contact you for documentation if we are unable to verify LIS status with Medicare.*

☐ Applied. *A printout of the LIS application receipt dated within the current calendar year **must be attached**.*

☐ Denied. *A printout of the LIS denial letter dated within the last 12 months **must be attached**.*

3. If you have **MEDICARE PART B,** what type of assistance are you requesting from LA HAP?

☐ Health Premiums. **Fill** in the information in SECTION 9. ☐ Health Copays and Deductibles ☐ No assistance requested

4. Medicare Part A and B Number with Letter (on your red, white, and blue Medicare card)	5. Medicare Part B Effective Date (MM/DD/YYYY)

6. If you have **MEDICARE PART C,** what type of assistance are you requesting from LA HAP?

☐ Health Premiums. **Fill** in the information in SECTION 9. ☐ Dental Premiums. **Fill** in the information in SECTION 9.

☐ Health Copays and Deductibles ☐ Dental Copays and Deductibles

☐ Drug Copays and Deductibles ☐ Vision Copays and Deductibles ☐ No assistance requested

7. Medicare Part C Company & Plan Name

8. Medicare Part C Member ID / Policy #	9. Medicare Part C Group #

10. Medicare Part C Start Date (MM/DD/YYYY)	11. Does your Medicare Part C plan provide drug coverage? ☐ Yes. **Skip** to 17. ☐ No

12. If you have **MEDICARE PART D, w**hat type of assistance are you requesting from LA HAP?

☐ Drug Premiums. **Fill** in the information in SECTION 9. ☐ Drug Copays and Deductibles ☐ No assistance requested

13. Medicare Part D Company & Plan Name

14. Medicare Part D Member ID / Policy #	15. Medicare Part D Group #	16. Medicare Part D Start Date (MM/DD/YYYY)

17. If you have **MEDICARE SUPPLEMENT,** what type of assistance are you requesting from LA HAP?

☐ Health Premiums. **Fill** in the information in SECTION 9. ☐ Health Copays and Deductibles ☐ No assistance requested

18. Medicare Supplemental Company & Plan Name

19. Medicare Supplemental Member ID/Policy#	20. Medicare Supplemental Group#	21. Medicare Supplemental Start Date (MM/DD/YYYY)

First Name:	Last Name:

SECTION 9: MEDICARE INSURANCE PREMIUM INFORMATION ☐ **Not applicable; not requesting premium assistance**

REQUIRED DOCUMENT(S): If you're requesting premium assistance AND (a) you're a new LA HAP client, or (b) you're already a LA HAP client and this is a new plan/the first time you are asking for premium assistance with this plan, you must include a copy of your premium invoice or coupon booklet. **If you receive any refund or money from the IRS, your insurance company or another source because your premium was overpaid, you MUST return that refund or money to LA HAP.**

1. **MEDICARE PART B** Insurance Company **or** Third Party Administrator Name (Who should the premium check be made out to?)

2. Medicare Part B Insurance Company **or** Third Party Administrator Street Address (Where should the premium check be sent?)

3. City	4. State	5. ZIP Code

6. What is your portion of the Part B premium amount? $_____	7. How often is the Part B premium paid? ☐ Monthly ☐ Quarterly (every 3 months) ☐ Semi-Annually (twice a year)
8. Next Payment Due Date (MM/DD/YYYY)	9. Regular Payment Due Date ☐ 1st ☐ 15th ☐ Other:_____

10. Do you have any premium payments that are past due?
☐ Yes. **Past due balances must be paid before LA HAP can assist with insurance premium payments.** ☐ No

11. **MEDICARE PART C** Insurance Company **or** Third Party Administrator Name (Who should the premium check be made out to?)

12. Medicare Part C Insurance Company **or** Third Party Administrator Street Address (Where should the premium check be sent?)

13. City	14. State	15. ZIP Code

16. What is your portion of the Part C premium amount? $_____	17. How often is the Part C premium paid? ☐ Monthly ☐ Quarterly (every 3 months) ☐ Semi-Annually (twice a year)
18. Next Payment Due Date (MM/DD/YYYY)	19. Regular Payment Due Date ☐ 1st ☐ 15th ☐ Other:_____

20. Do you have any premium payments that are past due?
☐ Yes. **Past due balances must be paid before LA HAP can assist with insurance premium payments.** ☐ No

21. **MEDICARE PART D** Insurance Company **or** Third Party Administrator Name (Who should the premium check be made out to?)

22. Medicare Part D Insurance Company **or** Third Party Administrator Street Address (Where should the premium check be sent?)

23. City	24. State	25. ZIP Code

26. What is your portion of the Part D premium amount? $_____	27. How often is the Part D premium paid? ☐ Monthly ☐ Quarterly (every 3 months) ☐ Semi-Annually (twice a year)
28. Next Payment Due Date (MM/DD/YYYY)	29. Regular Payment Due Date ☐ 1st ☐ 15th ☐ Other:_____

30. Do you have any premium payments that are past due?
☐ Yes. **Past due balances must be paid before LA HAP can assist with insurance premium payments.** ☐ No

31. **MEDICARE SUPPLEMENTAL** Insurance Company **or** Third Party Administrator Name (Who should the premium check be made out to?)

32. Medicare Supplemental Insurance Company **or** Third Party Administrator Street Address (Where should the premium check be sent?)

33. City	34. State	35. ZIP Code

36. What is your Medicare Supplemental premium amount? $_____	37. How often is the Medicare Supplemental premium paid? ☐ Monthly ☐ Quarterly (every 3 months) ☐ Semi-Annually (twice a year)
38. Next Payment Due Date (MM/DD/YYYY)	39. Regular Payment Due Date ☐ 1st ☐ 15th ☐ Other:_____

40. Do you have any premium payments that are past due?
☐ Yes. **Past due balances must be paid before LA HAP can assist with insurance premium payments.** ☐ No

First Name:	Last Name:

SECTION 10: NON-MEDICARE HEALTH INSURANCE POLICY INFORMATION
You may submit this form without the Member ID/Policy # and Group #. However, the Member ID/Policy # and Group # (if applicable) **must be submitted to LA HAP within 2 months of the policy start date** to continue LA HAP insurance assistance.

1. What type of **NON-MEDICARE HEALTH INSURANCE** policy do you have?
☐ Marketplace ☐ Individual (Non-marketplace) ☐ Group / Employer Sponsored ☐ COBRA
☐ Retiree Group Health ☐ Other Public Coverage (Example: Veterans/TRICARE) ☐ Other, specify: _____

2. What type of assistance are you requesting from LA HAP for this health policy? **Check all that apply**
☐ Health Premiums. **Fill** in the information in SECTION 11. ☐ Health Copays and Deductibles ☐ Drug Copays and Deductibles
☐ No assistance requested

3. Health Insurance Company & Plan Name (Example: Blue Cross Blue Shield Blue Max 100/80 $1800)

4. Health Member ID/Policy # (leave blank if not assigned yet)	5. Health Group # (if applicable; leave blank if not assigned yet)
6. Health Policy Start Date (MM/DD/YYYY)	7. COBRA Policy End Date (MM/DD/YYYY) ***Required only for COBRA***

8. Does your health insurance provide prescription drug coverage? ☐ Yes ☐ No

9. Do you have another health (not dental or vision) insurance policy for which you are requesting assistance?
☐ Yes. **Attach** another copy of this page to your application filled out with the information for your secondary policy. ☐ No

SECTION 11: NON-MEDICARE HEALTH INSURANCE PREMIUM INFORMATION ☐ **Not applicable; not requesting premium assistance**

REQUIRED DOCUMENT(S): If you're requesting premium assistance AND (a) you're a new LA HAP client, or (b) you're already a LA HAP client and this is a new plan/the first time you are asking for premium assistance with this plan, you must include a copy of your premium invoice or coupon booklet. Premiums are usually paid directly to the insurance company or third party administrator but can be paid to your employer, if your employer is willing to accept payments from LA HAP. Ask your provider or contact LA HAP for more information. **If you receive any refund or money from the IRS, insurance company or another source because your premium was overpaid, you MUST return that refund or money to LA HAP.**

1. **PRIMARY HEALTH INSURANCE** Company, Employer, **or** Third Party Administrator Name (Who should the premium check be made out to?)

2. Primary Health Insurance Company, Employer, **or** Third Party Administrator Street Address (Where should the premium check be sent?)

3. City	4. State	5. ZIP Code

6. What is your portion of the primary health premium amount? $_____	7. How often is the premium paid? ☐ Monthly ☐ Quarterly ☐ Semi-Annually
8. Next Payment Due Date (MM/DD/YYYY)	9. Regular Payment Due Date ☐ 1st ☐ 15th ☐ Other: _____

10. Do you have any premium payments that are past due?
☐ Yes. **Past due balances must be paid before LA HAP can assist with insurance premium payments.** ☐ No

First Name:	Last Name:

SECTION 12: DENTAL/VISION INSURANCE POLICY INFORMATION

If the insurance company requires a premium payment before the policy will start, you may submit this form without the Member ID/Policy # and Group # (questions 5 and 6 below) to allow initial premium payment. However, the Member ID/Policy # and Group # (if applicable) **must be submitted to LA HAP within 2 months of the policy start date** to continue LA HAP insurance assistance.

1. What type of **DENTAL INSURANCE** policy do you have? ☐ Dental ONLY ☐ Combined Dental and Vision

2. What type of assistance are you requesting from LA HAP for the **DENTAL INSURANCE** policy? **Check all that apply**

☐ Dental Premiums. **Fill** in the information in SECTION 13. ☐ Dental Copays and Deductibles ☐ No assistance requested

☐ Vision Premiums (included in dental premium amount) ☐ Vision Copays and Deductibles

3. Dental Insurance Company & Plan Name (Example: AlwaysCare ONEplus Preferred + Vision)

4. Dental Member ID/Policy #	5. Dental Group # (if applicable)	6. Dental Policy Start Date (MM/DD/YYYY)

7. Do you have stand-alone vision insurance coverage (vision ONLY) that is not included in a health and/or dental policy?

☐ Yes ☐ No. **Skip** to SECTION 13.

8. What type of assistance are you requesting from LA HAP for the **VISION INSURANCE** policy? **Check all that apply**

☐ Vision Premiums. **Fill** in the information in SECTION 13. ☐ Vision Copays and Deductibles

9. Vision Insurance Company & Plan Name (Example: HumanaVision Vision Care Plan)

10. Vision Member ID/Policy #	11. Vision Group # (if applicable)	12. Vision Policy Start Date (MM/DD/YYYY)

SECTION 13: DENTAL/VISION INSURANCE PREMIUM INFORMATION ☐ **Not applicable; not requesting premium assistance**

REQUIRED DOCUMENT(S): If you're requesting premium assistance AND (a) you're a new LA HAP client, or (b) you're already a LA HAP client and this is a new plan/the first time you are asking for premium assistance with this plan, you must include a copy of your premium invoice or coupon booklet. Premiums are usually paid directly to the insurance company or third party administrator but can be paid to your employer, if your employer is willing to accept payments from LA HAP. Ask your provider or contact LA HAP for more information. **If you receive any refund or money from the IRS, insurance company or another source because your premium was overpaid, you MUST return that refund or money to LA HAP.**

1. **DENTAL INSURANCE** Company, Employer, **or** Third Party Administrator Name (Who should the premium check be made out to?)

2. Dental Insurance Company, Employer, **or** Third Party Administrator Street Address (Where should the premium check be sent?)

3. City	4. State	5. ZIP Code

6. What is your portion of the dental premium amount? $_____	7. How often is the premium paid? ☐ Monthly ☐ Quarterly ☐ Semi-Annually
8. Next Payment Due Date (MM/DD/YYYY)	9. Regular Payment Due Date ☐ 1st ☐ 15th ☐ Other: _____

10. Do you have any premium payments that are past due?

☐ Yes. **Past due balances must be paid before LA HAP can assist with insurance premium payments.** ☐ No

11. **VISION INSURANCE** Company, Employer, **or** Third Party Administrator Name (Who should the premium check be made out to?)

12. Vision Insurance Company, Employer, **or** Third Party Administrator Street Address (Where should the premium check be sent?)

13. City	14. State	15. ZIP Code

16. What is your portion of the vision premium amount? $_____	17. How often is the premium paid? ☐ Monthly ☐ Quarterly ☐ Semi-Annually
18. Next Payment Due Date (MM/DD/YYYY)	19. Regular Payment Due Date ☐ 1st ☐ 15th ☐ Other: _____

20. Do you have any premium payments that are past due?

☐ Yes. **Past due balances must be paid before LA HAP can assist with insurance premium payments.** ☐ No

First Name:	Last Name:

SECTION 14: DIAGNOSIS & MEDICATION INFORMATION

1) My LA HAP eligibility has expired/will expire and I will run out of medication in the next 4 days. ☐ No ☐ Yes. **Fill** in 1a below.

1a) *If "yes":* Date you last filled your medication: _____

2) I have just been diagnosed with HIV OR I have just gotten back into care for my HIV. ☐ No ☐ Yes. **Fill** in 2a below.

2a) *If "yes":* Date you were diagnosed with HIV: _____

3) I have been told before that I have or had Hepatitis C (HCV). ☐ No ☐ Yes

SECTION 15: PROVIDER INFORMATION

1. Do you have one or more providers or case managers who you want to have access to your LA HAP records? ☐ Yes ☐ No

2. Provider 1 First and Last Name	3. Provider 1 Entity/Agency Name	4. Provider 1 Phone Number and Extension
5. Provider 2 First and Last Name	6. Provider 2 Entity/Agency Name	7. Provider 2 Phone Number and Extension

SECTION 16: ADDITIONAL COMMENTS

Please provide any additional comments you feel may be helpful in the review of this application.

SECTION 17: APPLICATION CHECKLIST

In completing this application, did you…

☐ Include proof of current income for everyone in your household age 18 or older?

☐ Include a copy of your statement or invoice for your insurance premium(s), if applicable?

☐ Include proof of your LIS application or status, if applicable?

☐ Sign and date the application?

SECTION 18: CLIENT RESPONSIBILITIES AND RELEASE OF CONSENT

By signing below I confirm that I understand the following:

- If I report any information that I know is false, my LA HAP services may be suspended or taken away.
- It's my responsibility to re-certify for LA HAP every six months.
- It's my responsibility to let LA HAP know anytime my contact/mailing information or insurance status changes.
- I might not be approved for LA HAP if I don't send all the required documents.
- LA HAP can only provide services if my enrollment is active and not expired, and if program funds are available.
- Being approved for LA HAP doesn't change the address I have on file with my insurance company. I understand that if my contact/mailing information changes, I need to let both LA HAP and my insurance company know.
- My insurance company and others will continue to mail to me, and not to LA HAP, information about my insurance including bills, premium information, and benefit information. It's my responsibility to send this information to LA HAP if it relates to my LA HAP services.
- The information from my application is being entered into an electronic database that can be seen by staff at other agencies where I get Ryan White services.
- I agree to let LA HAP get, check, and/or share my demographic, medical, prescription, and/or insurance information if it's needed to help me get my medications, healthcare, and/or premium payments.
- My information may be shared with, but is not limited to, the following: doctor, health department staff, treatment center staff, pharmacy staff, clinic, insurance broker, insurance company, Medicare, Medicaid, CCIIO, CMS, SSA, SSDI, and other Louisiana agencies where I get Ryan White services.
- Ryan White money (including LA HAP assistance) should only be spent if there are no other payment sources available. I must apply for any other assistance I may be eligible for such as Medicaid, Medicare including Extra Help, insurance, and Social Security.
- If my insurance company, the IRS, or another third-party payer refunds me any money that LA HAP paid them, such as a premium tax credit overpayment, this money belongs to LA HAP and must be given to them immediately. If I don't do this, I may lose my eligibility for LA HAP.

This consent will remain in effect as long as I/my dependent remain enrolled for services through LA HAP.

I have read, understand, and agree to the above Client Responsibilities and Release of Consent. I verify that the information provided in this application is complete and accurate to the best of my knowledge.

_____ _____

Signature of Applicant or, if under 18, Parent/Legal Guardian ONLY | Date Signed

_____ _____

PRINT First and Last Name of Applicant or, if under 18, Parent/Legal Guardian ONLY | Relationship to Applicant (if applicable)