



APPLICATION FOR MEDICATION ASSISTANCE

Texas HIV Medication Program
 ATTN: MSJA - MC 1873
 PO Box 149347, Austin, TX 78714-9347
 1-800-255-1090

- Please print clearly and answer all questions
- For help with this application call 1-800-255-1090
- Mail the completed application and copies of supporting documentation to the address listed above
- Do not send original documents, they will not be returned
- Detailed instructions are available at www.dshs.state.tx.us/hivstd/meds or by calling 1-800-255-1090

SECTION I – PERSONAL INFORMATION

1. Last Name	First Name	Middle Name	Suffix (Jr., Sr., III)
2. Social Security Number:		3. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender: Male to Female <input type="checkbox"/> Transgender: Female to Male	4. If female, are you currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Due Date: / /
5. Date of Birth:			
6. Race (check all that apply) <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Other/Unknown		7. Ethnicity (check the one that best describes you) <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	
8. Residential Street Address – (No P.O. Boxes or Rural Routes)			Apartment Number
City	State	Zip Code	
<i>If you wish to have mail sent somewhere other than your residential address please provide an alternate mailing address:</i>			
9. Mailing Address - (P.O. Boxes and Rural Routes accepted here)			Apartment Number
City	State	Zip Code	
10. Home Phone Number (area code + number)		Work/Alternate Phone (area code + number)	
May we leave a message on your voice mail or answering machine? <input type="checkbox"/> Yes <input type="checkbox"/> No		May we leave a message on your voice mail or answering machine? <input type="checkbox"/> Yes <input type="checkbox"/> No	
11. In order to process your application faster, we may need to call you with additional questions. If you are unavailable, are there any special instructions as to how we should leave a message for you? 			
12. Have you recently been released or are you currently incarcerated in a jail or prison? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, continue to next page			
Facility Name		TDCJ or SPN Number	Release Date (or expected release date)
Approximate Length of Incarceration:			

SECTION IV – INCOME, EMPLOYMENT and BENEFITS

18. Please give a brief explanation of how you support yourself: For example: I work full time, I'm on disability, I don't work and live with a relative who provides room and board, or I'm a student.

19. Employment: Please complete the table for employment status. If you are not working, make sure you list where and when you were last employed. This program may verify your income with other sources such as the Texas Workforce Commission.

	Applicant	Spouse	Required Documentation
a. Employment Status	<input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Unemployed <input type="checkbox"/> Temporary <input type="checkbox"/> Seasonal <input type="checkbox"/> Student <input type="checkbox"/> Self Employed	<input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Unemployed <input type="checkbox"/> Temporary <input type="checkbox"/> Seasonal <input type="checkbox"/> Student <input type="checkbox"/> Self Employed	If you have never worked or are a full time student please explain this in the top section or in the space provided at the end of the application.
b. If employed Employer Name			- If you work more than one job list all employers in the section above. - If you have recently changed jobs please indicate this in the section above.
Job Title			
c. If unemployed Where were you last employed			- Provide pay stubs for all current employment. - If you are paid in cash have your employer complete the Income Verification form.
Date employment ended	/ /	/ /	

20. Income and Benefits: Please complete the table for all income received. Report monthly gross income. Gross income is the amount received before any taxes or deductions are taken. Submit documentation for all income.

	Applicant	Spouse	
Wages, salary, commissions, tips	\$	\$	At least Two (2) current, consecutive pay stubs or earnings statements. If paid weekly, four (4) consecutive pay stubs will be required.
Self employment income	\$	\$	A completed copy of your most recent Federal Income Tax Return. Please note that per IRS regulations, anyone with net self-employment earnings of more than \$400 is required to file a Federal Tax Return for that calendar year.
Interest, cash dividends or investment income	\$	\$	
Unemployment Benefits/Income	\$	\$	A copy of your benefit award letter or any other official documentation showing the amount received on a regular basis.
Social Security Income (retirement or disability-SSDI)	\$	\$	
Supplemental Security Income (SSI)	\$	\$	
Retirement Pension or Annuities	\$	\$	
Veteran's Administration	\$	\$	
Other Disability Benefits/Income	\$	\$	
Food Stamps	\$	\$	
Temporary Assistance to Needy Families (TANF) Benefits	\$	\$	
Alimony/child support received	\$	\$	Source:
Other Income (specify source)	\$	\$	

If no income is reported, a supporter statement must be completed by the person who provides support. Please complete page 7 and submit with the application.

SECTION V – HEALTH INSURANCE

21. Are you currently taking medications for HIV (antiretroviral medications)? Yes No

If yes, please tell us how you are getting your medications.

22. What types of health care coverage or health insurance do you have?

Please check all that apply. If a card is issued provide a copy of the front and back of the card.

- Health Insurance offered by my employer (examples: Blue Cross Blue Shield, Aetna, Humana)
- Health Insurance offered by the employer of my spouse, parent or domestic partner
- Private Health Insurance that I purchased on my own or someone else helped me purchase
- Medicaid (including Star and Star +)
- Children's Health Insurance Program (CHIP)
- Medicare (Part A, Part B, Part C or Part D)
- COBRA - continued group health coverage offered to you after leaving an employer plan
- High Risk Pool (Texas or Federal)
- Veterans Administration Health Benefits
- City or County Indigent Program (examples: MAP, Gold Card, Parkland Plus, Wilco, Carelink)
- Other: _____
- I don't have any health coverage or health insurance

23. Have you previously had any health insurance: Yes No If yes, please list name and date coverage ended.

Insurance Name:

End Date:

Insurance Name:

End Date:

Insurance Name:

End Date:

24. If you currently have health care coverage or health insurance, why are you applying for this program?
(Please check ALL that apply, and submit supplemental documentation from the insurance plan verifying your situation.)

- My insurance does not cover prescription drugs.
- One or more HIV/AIDS medications I need are not covered by the plan.
- Coverage will end soon (specify expiration date): _____
- I have Medicare and I need help paying the medication deductibles, copays or coinsurance (please complete the SPAP enrollment form)
- Expenses have or are about to exceed the plan's annual prescription cap.
Amount of annual prescription cap: \$_____
- HIV/AIDS is a pre-existing condition for my health insurance plan. If known, please specify the date that the pre-existing condition limit in your insurance plan will be met: _____
- Other limitations on coverage or payment (specify): _____

SECTION VI: ADDITIONAL INFORMATION

25. Is there anything you would like to clarify on this application? Please use this space to provide any additional information that may help THMP process your application. Attach additional pages if needed.

SECTION VII: APPLICANT CERTIFICATION AND AUTHORIZATION

Authorization to release confidential information: I am authorizing the following individual(s) to speak to the THMP on my behalf regarding my application and eligibility status. The individuals may be friends and family members, or they may be care coordinators, social workers or other case managers operating on my behalf. This authorization is in effect until I revoke it in writing, which I may do at any time.

Name of Person	Relation to You or Agency Name	Phone Number

IMPORTANT – THE FOLLOWING CERTIFICATION AND AUTHORIZATION MUST BE SIGNED BY THE APPLICANT:

- a. I understand that this application is a legal document. My signature (1) attests that all the information given is true and correct, and (2) authorizes the release of my medical information to the Texas HIV Medication Program (THMP).
- b. I understand that it is my responsibility to notify the THMP immediately if my/our income increases; if I/we move from Texas; or if my/our marital, household or insurance status changes.
- c. I understand that the THMP may request verification of the information I have provided in order to process my application, and also at any time thereafter. I also understand that the processing of my application may be delayed until such requested verification is received.
- d. I understand that the THMP may verify information provided on this application with data resources made available to the program for the purpose of eligibility determination.
- e. I understand that deliberately omitting or giving false information could cause me to be removed from the THMP, or criminally prosecuted, or both.
- f. I understand that the THMP reserves the right to limit enrollment based upon availability of funds.
- g. I understand that the THMP is required to recertify my eligibility status per the program rules in order to continue receiving services.

Signature of Applicant	Date
Signature of Parent (if applicant is under 18 years of age)	Date

Is your application complete?

If your application is not complete when submitted, we won't be able to determine your eligibility. Did you:

- Answer all of the questions on the application?
- Include proof of Texas residency?
- Include proof of current income?
- Sign the application?
- Include the Medical Certification Form, completed and signed by your doctor?
- Include a copy of both sides of your health insurance card and information on how your prescription drug coverage works (if applicable)?

Do you need to include any additional forms?

- If you have zero income, include a supporter statement (page 7)
- If you have Medicare, include the SPAP Enrollment form (page 8)
- If you are under 18, include your parent's information (page 9)
- If you are paid in cash, include the income verification form signed by your employer (page 10)

If you have any questions please call the THMP at 1-800-255-1090.

Mail all application materials to:
Texas Department of State Health Services
Attn: MSJA - MC 1873
PO BOX 149347
Austin, Texas 78714-9347

PRIVACY NOTIFICATION

With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See <http://www.dshs.state.tx.us> for more information on privacy notification. (Reference: Texas Government Code, Sections 522.021, 522.023, 559.003 and 559.004)

For additional information, including a review of Frequently Asked Questions and downloadable copies of program documents, please visit the Texas HIV Medication Program web site at <http://www.dshs.state.tx.us/hivstd/meds>.

For additional information on AIDS service organizations, case management services and community resources in your local area, please call 2-1-1.

If you have any questions, comments or concerns regarding the Texas HIV Medication Program and this application for assistance, please call the program directly at 1-800-255-1090.

Once you have completed the application and gathered the necessary attachments, please mail the completed application to: Texas HIV Medication Program, ATTN: MSJA MC 1873, PO BOX 149347, Austin TX 78714-9347

(revised 04/2012)

SUPPORTER STATEMENT

If an applicant has no income or is unable to provide any documentation showing how they manage, this form can be used as documentation. This form must be completed and signed by the person providing support; it should not be filled out by the applicant.

I, _____, certify that I currently support
(Printed name of supporter)

_____, who resides at the following
(Printed name of applicant)

address: _____
(applicant's street address, city, state, & zip code)

I have supported him/her since _____ . My relationship to the applicant
(Date)

is _____. To the best of my knowledge, the monthly

income of the person I am supporting is: _____ .
(applicant's income)

The type of support I provide is (check all that apply):

Room Food/Clothing Rent/Mortgage Utility Bills

Cash Assistance in the amount of \$_____ per month

Other _____

Additional explanation (if necessary):

I can be reached at the following number(s) to verify this information: (____) _____

By signing this form, I affirm that the above information is an accurate statement of assistance being provided to the applicant. I understand that if I deliberately omit or give false information the applicant may be removed from the program and/or criminally prosecuted.

Signature of Supporter

Date

Please note: If there are special circumstances surrounding your household situation that would need to be explained or verified by a social worker, case manager, or public health nurse, please have them provide a detailed support statement on your behalf and attach it to your application when applying for assistance.



Phone: 1-800-255-1090
Fax: 512-371-4670

Enrollment -Texas HIV State Pharmacy Assistance Program

Mailing Address: Texas Department of State Health Services
ATTN: MSJA - MC 1873
PO Box 149347
Austin, TX 78714-9347

Applicants with MEDICARE should fill out this form. Individuals with Medicare who are eligible for assistance from the Texas HIV Medication Program (THMP) will be enrolled in the HIV State Pharmacy Assistance Program (SPAP) to obtain their medications. The SPAP helps with co-pays, coinsurance and gap coverage associated with a Medicare Part D prescription drug plan. **If you are not already enrolled in the THMP, you must also fill out the full THMP application.**

SECTION I – PERSONAL INFORMATION

Last Name	First Name	Middle Name	Date of Birth
Mailing Address		Phone Number (area code + number)	
May we leave a message on your voice mail or answering machine? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Your Social Security Number	Your Medicare Number	Effective Date of Medicare Part A (listed on your Red White & Blue Medicare Card)	

SECTION II – MEDICARE PRESCRIPTION DRUG INFORMATION

Are you enrolled in a Medicare Prescription Drug Plan (Part D)? Yes if yes, please provide plan information below.
 No

Plan Name:	Effective Date:		
ID Number:	RxBin:	RxPCN:	RxGroup:

SECTION III – LOW INCOME SUBSIDY

Have you applied for the Low Income Subsidy or Extra Help through the Social Security Administration? Yes - please indicate application status below.
 No - you need to apply for this assistance, please call 1-800-255-1090 to have an application mailed to you.

Low Income Subsidy/Extra Help Application Status

Approved, 100% Assistance Denied Assistance (attach a copy of pre-decisional or denial letter)
 Approved, partial assistance (attach copy of approval letter) Awaiting determination, application date: _____

SECTION IV – SPAP AGREEMENT

- 1) I understand that it is my responsibility to:
 - a) enroll in a Medicare Prescription Drug Plan,
 - b) maintain my enrollment in a Medicare Prescription Drug Plan, and
 - c) pay the monthly prescription drug plan premium directly to the prescription drug plan.
- 2) I understand that it is my responsibility to notify the Texas HIV SPAP immediately if any of the following happen:
 - a) my household income increases,
 - b) my address changes or I move out of the State of Texas,
 - c) my marital, household or insurance status changes, or
 - d) my Medicare benefits are terminated.
- 3) I understand that the Texas HIV SPAP reserves the right to limit enrollment based upon availability of funds.
- 4) I understand that the Texas HIV SPAP is required to recertify my eligibility status every other year per program rules in order to continue receiving services.
- 5) I understand that this is a legal document. My signature (1) attests that all the information given is true and correct, (2) authorizes the release of my medical information to the Texas HIV Medication Program, including the Texas HIV SPAP, and (3) attests that I do reside in the State of Texas.

Signature of Applicant	Date
Signature of Parent (if applicant is under 18)	Date

PARENT INFORMATION

If an applicant is under the age of 18 this form must be filed out by the parent (s) who live with the applicant.

A. Name of Parent		B. Name of Parent (if applicable)	
Social Security Number	Date of Birth	Social Security Number	Date of Birth

Employment: Please complete the table for employment status of the applicant's parents. If you are not working make sure you list where and when you were last employed. Employment may be verified with other sources such as the Texas Workforce Commission.

	Parent (a)	Parent (b)	Required Documentation
a. Employment Status			Full time, part time, unemployed, seasonal etc.
b. If employed Employer Name			- If you work more than one job list all employers in the section above. - If you have recently changed jobs please indicate this in the section above. - Provide pay stubs for all current employment. - If you are paid in cash have your employer complete the Income Verification form.
Job Title			
c. If <u>un</u> employed Where were you last employed			
Date employment ended	/ /	/ /	

Income and Benefits: Please complete the table for all income received by the parent. Report monthly gross income. Gross income is the amount received before any taxes or deductions are taken. Submit documentation for all income. If the child receives income this should be reported on page 3 of the application.

Wages, salary, commissions, tips	\$	\$	At least Two (2) current, consecutive pay stubs or earnings statements. If paid weekly, four (4) consecutive pay stubs will be required.	
Self-employment income	\$	\$	A completed copy of your most recent Federal Income Tax Return. Please note that per IRS regulations, anyone with net self-employment earnings of more than \$400 is required to file a Federal Tax Return for that calendar year. A copy of your benefit award letter or any other official documentation showing the amount received on a regular basis.	
Interest, cash dividends or investment income	\$	\$		
Unemployment Benefits/Income	\$	\$		
Social Security Income (retirement or disability benefits)	\$	\$		
Supplemental Security Income (SSI)	\$	\$		
Retirement Pension or Annuities	\$	\$		
Veteran's Administration	\$	\$		
Other Disability Benefits/Income	\$	\$		
Food Stamps	\$	\$		
Temporary Assistance to Needy Families (TANF) Benefits	\$	\$		
Alimony/child support received	\$	\$		
Other Income (specify source)	\$	\$		Source:

INSURANCE

Does the parent(s) have any type of health insurance or health coverage?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
If yes, is the applicant (child) covered under the policy?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
If no, is family coverage offered by the parent's health insurer or employer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

* If yes, provide a copy of both sides of the insurance card and include documentation as to how your prescription coverage works.

INCOME VERIFICATION

This form should be used only when no supporting income documentation is available. If paystubs are available to the employee copies must be submitted.

I. Employee Information

Employee Name:

Employee Address:

II. Employer Contact Information

Business Name:

Business Address:

Business Phone Number:

Contact Name:

Contact Phone Number:

III. Employee Income

Type of work performed by the employee:

First Day of Employment:

Average number of hours worked per week:

The employee is paid by (*check one*):

Cash Personal check Payroll check Other (please specify) _____

The employee is paid (*check one*):

Weekly Biweekly Semi-monthly Monthly Daily Other (please specify) _____

The employee receives a gross amount of \$ _____ per pay period

The employee's gross **hourly** wage: \$ _____ *per hour*

The employee receives **weekly** tips or commissions in this estimated amount: \$ _____ *per week*

IV. Employee Health Coverage

Is the employee offered health coverage? Yes No

If yes, is this employee enrolled in health coverage? Yes No

V. Additional Information

Will there be any changes to this person's employment in the next few months?

VI. Certification

I verify that the above information is true and correct to the best of my knowledge.

Signature of Employer

Date

