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.

STEP 1: APPLICANT ASSISTANCE INFORMATION

1. What type of assistance are you applying for? **Check all that apply**

Insurance **premiums:** ☐ health ☐ dental ☐ vision

Insurance **copays/ deductibles:** ☐ health ☐ dental ☐ vision

☐ Insurance **drug copays and deductibles**

☐ No Insurance: **medications only**

STEP 2: APPLICANT AND CONTACT INFORMATION

1. First Name	2. Middle Initial	3. Last Name	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. Do you want to receive information from LA HAP by email? ☐ Yes. **Fill** in your email address in question 10. ☐ No. **Skip** to question 11.

10. Email Address

11. Language Preference (if not English)

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

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

14. Apartment/Unit #

15. City

16. State

17. ZIP Code

18. 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 24. ☐ No. Do not send mail or my card to my residential address. **Fill** in your mailing address in question 19.

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

20. Apartment/Unit #

21. City

22. State

23. ZIP Code

24. Home Phone (_____)_____-_____

May LA HAP leave a detailed voice mail on your home phone? ☐ Yes ☐ No ☐ No home phone

25. Cell Phone (_____)_____-_____

May LA HAP leave a detailed voice mail on your cell phone? ☐ Yes ☐ No ☐ No cell phone

26. Work Phone (_____)_____-_____

May LA HAP leave a detailed voice mail on your work phone? ☐ Yes ☐ No ☐ No work phone

27. Do you have a friend or family member (alternate contact) that LA HAP may speak to on your behalf? ☐ Yes. **Fill** in your alternate contact's information in questions 28-30. ☐ No. **Skip** to question 31.

28. Alternate Contact's Name

29. Alternate Contact's Relationship

30. Alternate Contact's Phone Number

31. What is the best way for LA HAP to reach you? ☐ by phone ☐ by postal mail ☐ through my alternate contact

First Name:	Last Name:

STEP 3: DEMOGRAPHIC INFORMATION

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

2. Are you currently pregnant? ☐ Male - Not Applicable ☐ Yes – Due Date: _____/_____ ☐ No

3. Race: **(both race and ethnicity must be provided)**

☐ Amer. Indian or AK Native ☐ Asian ☐ Black / African American ☐ Native Hawaiian or Pacific Islander ☐ White / Caucasian ☐ Other

4. Ethnicity: **(both race and ethnicity must be provided)** ☐ Hispanic ☐ Non-Hispanic

5. Relationship Status: **("Partnered" can be checked in addition to "Divorced," "Separated," or "Widowed," if applicable.)**

☐ Single: *never married and not living with girlfriends, boyfriends, partners, or significant others*
☐ Married – State & Federally recognized: *legally married as defined by Louisiana*
☐ Married – Federally recognized only: *legally married in another state but not legally married as defined by Louisiana*
☐ Divorced: *was legally married but is no longer legally married*
☐ Separated: *legally married but living apart from legal spouse* **Date Separated: _____**
☐ 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*

STEP 4: HOUSEHOLD INFORMATION

*Household is considered all persons related by blood, state defined legal marriage, and/or legal adoption living in the same dwelling. Household size does not include "common law" spouses, girlfriends, boyfriends, partners, or significant others. A legally married couple that is separated and are not living together will be considered separate households.

1. Including you, what is the number of persons in your household*? _____ **Cannot be 0**. If one (1), **skip** to question 3.

2. If the number of persons in your household is greater than one (1), list each household member's age and his/her relationship to you below. **Income documentation is required for all household* members age 18 or older.**

Relationship	Age **or** Date of Birth
a.	
b.	
c.	
d.	
e.	
f.	

3. Is there anything else you would like to tell us about your living situation that could help clarify your application?
Example: I recently moved and the address on my state residency documentation does not match my current address which is listed on the application.

STEP 5: APPLICANT EMPLOYMENT INFORMATION

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

☐ Employed – Full time ☐ Employed – Part time ☐ Employed – Seasonal/Temporary
☐ Student – Employed ☐ Student – Unemployed: **Skip** to STEP 6. ☐ Retired: **Skip** to STEP 6.
☐ Unemployed: **Skip** to STEP 6. ☐ Medically Unable to Work: **Skip** to STEP 6.

2. What is your employer's name? **If you have more than one employer, list all employers' names.** (Example: Bill's Lawn Service)

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

First Name:	Last Name:

STEP 6: HOUSEHOLD INCOME INFORMATION

Income documentation must be provided for all sources checked below for all household members age 18 or older. If the applicant is younger than 18, documentation is needed for each parent living in the home unless there are special circumstances.

1. Does your household receive income from any of the following source(s)? **Check all that apply**
Annual Gross Amount to be calculated by LA HAP staff. Leave blank.

Income Source	Applicant	Household	Annual Gross Amount **(LA HAP staff use only)**	Acceptable Forms of Income Documentation
a. Salary/Wages/Commission/Tips	☐	☐	$	Pay stub indicating time period covered; Current tax year document; or Legal affidavit stating income.
b. Alimony/Child Support	☐	☐	$	Benefit award letter; Legal documentation declaring the amount received on a routine basis; or Bank statement showing gross monthly deposit.
c. Food Stamps/SNAP	☐	☐	$	
d. Supplemental Security Income (SSI)	☐	☐	$	
e. Social Security Retirement/Survivor's Income	☐	☐	$	
f. Social Security Disability Income (SSDI) **SSDI start date _____/_____/_____**	☐	☐	$	
g. Retirement/Pension	☐	☐	$	
h. Unemployment Benefits	☐	☐	$	
i. Veterans Administration (VA) Pension/Benefits	☐	☐	$	
j. No Income of any kind	☐	☐	$ 0	Legal affidavit stating lack of income; Certification of No Income; or Statement from unemployment office verifying no record of employment;
k. Other Income, fill in source below: _____	☐	☐	$	If other, must specify source and provide income documentation.
Total Annual Household Income **(LA HAP staff use only)**			$	

2. Have you applied for Social Security Income (SSI)? ☐ Yes – application date _____/_____ ☐ No

3. Have you applied for Social Security Disability Income (SSDI)? ☐ Yes – application date _____/_____ ☐ No

4. Is there anything else you would like to tell us about your household income that could help clarify your application?

STEP 7: GENERAL HEALTH INSURANCE INFORMATION

1. Do you currently have health insurance coverage of **any** kind? ☐ Yes. **Skip** to STEP 8. ☐ No

2. Have you had health insurance of any kind in the last 2 months?
☐ Yes. You may be eligible for a marketplace insurance special enrollment period (SEP). Ask your provider or contact LA HAP for more info. ☐ No

3. Do you have Medicaid/Bayou Health? ☐ Yes ☐ No ☐ Applied - application date _____/_____

4. Do you have Medicare? ☐ Yes – Part A ☐ Yes – Part B ☐ No. **Skip** to question 7.

5. Do you have Medicare Part D?
☐ Yes ☐ No. Individuals with Medicare A and/or B are required to enroll in a Part D Plan. Ask your provider or contact LA HAP for more info. ☐ Applied - application date _____/_____

6. Do you have Low Income Subsidy (LIS) or receive "Extra Help"?
☐ Yes ☐ No. Individuals with Medicare are required to apply for LIS before LA HAP can assist with medication and/or insurance costs. Ask your provider or contact LA HAP for more info. ☐ Applied - application date _____/_____

7. Did you answer "Yes" to any of questions 3-5? ☐ Yes. You have health insurance. **Skip** to STEP 8. ☐ No

8. Do you have dental insurance coverage that is not included in a health insurance policy?
☐ Yes. **Skip** to STEP 11. ☐ No. **Skip** to STEP 12.

First Name:	Last Name:

STEP 8: PRIMARY HEALTH INSURANCE POLICY INFORMATION

Required documents: If you are requesting premium assistance AND (a) you are a new LA HAP client, or (b) you are 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. **Failure to submit required insurance documentation will result in your application being delayed.**

1. Primary Health Insurance Policy Type: **Check only one**

☐ Medicaid / Bayou Health ☐ Medicare Part A ☐ Medicare Part B ☐ Medicare Part C ☐ Medicare Part D

☐ Marketplace policy ☐ Individual (Non-marketplace) Policy ☐ Group / Employer sponsored policy

☐ Other Public Coverage (Ex: Veterans & TRICARE) ☐ COBRA **Skip** to STEP 10. ☐ Other, specify: _____

2. Insurance Company & Plan Name (Example: Aetna/Max 1500)	3. Insurance Company Customer Service Phone Number
4. Member ID / Policy # ***REQUIRED***	5. Group # (if applicable)
6. Policy Start Date (MM/DD/YYYY)	7. Policy End Date (MM/DD/YYYY)

8. Does your primary insurance provide prescription drug coverage? ☐ Yes ☐ No. **Skip** to question 12.

9. Is there a drug benefit cap or maximum?	10. Is there a cap on brand name drugs?	11. What is the cap amount and the cap time period? (ex $500/month)
☐ Yes ☐ No	☐ Yes ☐ No	_____ ☐ None

12. Are you requesting insurance premium assistance?

☐ Yes. **Fill** in your insurance premium payment information in questions 13-24. ☐ No. **Skip** to question 25.

Premiums are usually paid directly to the insurance company, 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.

13. Who is the best person to contact if LA HAP has questions about your insurance premium payment? **(Contact Person Name)**	14. What is the best phone number to reach the contact person in question 13? **(Contact Person Phone Number)**

15. Who should the premium check be made out to? (Insurance Company **or** Employer Name)

16. Where should the premium check be sent? (Insurance Company **or** Employer Street Address)

17. City	18. State	19. ZIP Code

20. What is the applicant's portion of the insurance premium amount?	21. How often is the premium paid?
$_____	☐ Monthly ☐ Quarterly ☐ Semi-Annually (twice a year)

22. Next Payment Due Date (MM/DD/YYYY)	23. Regular Due Date (MM/DD/YYYY)

24. 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. Ask your provider or contact LA HAP for more info about resources that might be able to help pay your past due balances. ☐ No

25. Do you have dental insurance coverage that is not included in a health insurance policy?

☐ Yes. **Skip** to STEP 11. ☐ No

26. Do you have a secondary health insurance policy? ☐ Yes. **Fill** in policy info in STEP 9. ☐ No. **Skip** to STEP 12.

First Name:	Last Name:

STEP 9: SECONDARY HEALTH INSURANCE POLICY INFORMATION

Required documents: If you are requesting premium assistance AND (a) you are a new LA HAP client, or (b) you are 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. **Failure to submit required insurance documentation will result in your application being delayed.**

1. Secondary Health Insurance Policy Type: **Check only one**

☐ Medicaid / Bayou Health ☐ Medicare Part A ☐ Medicare Part B ☐ Medicare Part C ☐ Medicare Part D

☐ Marketplace policy ☐ Individual (Non-marketplace) Policy ☐ Group / Employer sponsored policy

☐ Other Public Coverage (Ex: Veterans & TRICARE) ☐ COBRA **Skip** to STEP 10. ☐ Other, specify: _____

2. Insurance Company & Plan Name (Example: Aetna/Max 1500)	3. Insurance Company Customer Service Phone Number
4. Member ID / Policy # ***REQUIRED***	5. Group # (if applicable)
6. Policy Start Date (MM/DD/YYYY)	7. Policy End Date (MM/DD/YYYY)

8. Does your secondary insurance provide prescription drug coverage? ☐ Yes ☐ No. **Skip** to question 12.

9. Is there a drug benefit cap or maximum?	10. Is there a cap on brand name drugs?	11. What is the cap amount and the cap time period? (ex $500/month)
☐ Yes ☐ No	☐ Yes ☐ No	_____ ☐ None

12. Are you requesting insurance premium assistance?

☐ Yes. **Fill** in your insurance premium payment information in questions 13-24. ☐ No. **Skip** to question 25.

Premiums are usually paid directly to the insurance company, 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.

13. Who is the best person to contact if LA HAP has questions about your insurance premium payment? **(Contact Person Name)**	14. What is the best phone number to reach the contact person in question 13? **(Contact Person Phone Number)**

15. Who should the premium check be made out to? (Insurance Company **or** Employer Name)

16. Where should the premium check be sent? (Insurance Company **or** Employer Street Address)

17. City	18. State	19. ZIP Code

20. What is the applicant's portion of the insurance premium amount?	21. How often is the premium paid?
$_____	☐ Monthly ☐ Quarterly ☐ Semi-Annually (twice a year)

22. Next Payment Due Date (MM/DD/YYYY)	23. Regular Due Date (MM/DD/YYYY)

24. 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. Ask your provider or contact LA HAP for more info about resources that might be able to help pay your past due balances. ☐ No

25. Do you have dental insurance coverage that is not included in a health insurance policy?

☐ Yes. **Skip** to STEP 11. ☐ No

26. Do you have any additional health insurance policies?

☐ Yes. **STOP.** Ask your provider or contact LA HAP for the *Additional Health Insurance Policy Information* Form. ☐ No. **Skip** to STEP 12.

First Name:	Last Name:

STEP 10: COBRA POLICY INFORMATION

Required documents: If you are requesting premium assistance AND (a) you are a new LA HAP client, or (b) you are 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. **Failure to submit required insurance documentation will result in your application being delayed.**

1. COBRA Insurance Policy Type: **Check all that apply**

☐ Medical ☐ Dental ☐ Vision

2. Insurance Company & Plan Name (Example: Aetna/Max 1500)	3. Insurance Company Customer Service Phone Number
4. COBRA Member ID / Policy # ***REQUIRED***	5. COBRA Group # (if applicable)
6. COBRA Start Date (MM/DD/YYYY) ***REQUIRED***	7. COBRA End Date (MM/DD/YYYY) ***REQUIRED***

8. Does your COBRA insurance provide prescription drug coverage? ☐ Yes ☐ No. **Skip** to question 12.

9. Is there a drug benefit cap or maximum?	10. Is there a cap on brand name drugs?	11. What is the cap amount and the cap time period? (ex $500/month)
☐ Yes ☐ No	☐ Yes ☐ No	_____ ☐ None

12. Are you requesting insurance premium assistance?

☐ Yes. **Fill** in your insurance premium payment information in questions 13-24. ☐ No. **Skip** to question 25.

COBRA Premiums are usually paid directly to the former employer, third party administrator, or insurance company. Your COBRA letter should contain the premium payment information.

13. Who is the best person to contact if LA HAP has questions about your insurance premium payment? **(Contact Person Name)**	14. What is the best phone number to reach the contact person in question 13? **(Contact Person Phone Number)**

15. Who should the premium check be made out to? (Former Employer, Third Party Administrator, **or** Insurance Company Name)

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

17. City	18. State	19. ZIP Code

20. What is the applicant's portion of the insurance premium amount?	21. How often is the premium paid?
$_____	☐ Monthly ☐ Quarterly ☐ Semi-Annually (twice a year)

22. Next Payment Due Date (MM/DD/YYYY)	23. Regular Due Date (MM/DD/YYYY)

24. 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. Ask your provider or contact LA HAP for more info about resources that might be able to help pay your past due balances. ☐ No

25. Do you have dental insurance coverage that is not included in a health insurance policy?

☐ Yes. **Skip** to STEP 11. ☐ No

26. Do you have a secondary health insurance policy? ☐ Yes. **Fill** in policy info in STEP 9 on page 5. ☐ No. **Skip** to STEP 12.

First Name:	Last Name:

STEP 11: DENTAL INSURANCE POLICY INFORMATION

Required documents: If you are requesting premium assistance AND (a) you are a new LA HAP client, or (b) you are 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. **Failure to submit required insurance documentation will result in your application being delayed.**

1. Do you have dental insurance coverage that is included in a health insurance policy?

☐ Yes. You have health insurance. **GO BACK** to STEP 8 and fill in your health insurance policy information. ☐ No

2. Dental Insurance Company & Plan Name (Example: Dearborn 100)	3. Insurance Company Customer Service Phone Number
4. Member ID / Policy # ***REQUIRED***	5. Group # (if applicable)
6. Policy Start Date (MM/DD/YYYY)	7. Policy End Date (MM/DD/YYYY)

8. Are you requesting dental insurance premium assistance?

☐ Yes. **Fill** in your dental insurance premium payment information in questions 9-20. ☐ No. **Skip** to question 21.

Premiums are usually paid directly to the insurance company, 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.

9. Who is the best person to contact if LA HAP has questions about your insurance premium payment? **(Contact Person Name)**	10. What is the best phone number to reach the contact person in question 13? **(Contact Person Phone Number)**

11. Who should the premium check be made out to? (Insurance Company **or** Employer Name)

12. Where should the premium check be sent? (Insurance Company **or** Employer Street Address)

13. City	14. State	15. ZIP Code

16. What is the applicant's portion of the insurance premium amount? $_____	17. How often is the premium paid? ☐ Monthly ☐ Quarterly ☐ Semi-Annually (twice a year)
18. Next Payment Due Date (MM/DD/YYYY)	19. Regular Due Date (MM/DD/YYYY)

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. Ask your provider or contact LA HAP for more info about resources that might be able to help pay your past due balances. ☐ No

21. Do you have a secondary health insurance policy? ☐ Yes. **Fill** in policy info in STEP 9 on page 5. ☐ No

STEP 12: MEDICATION INFORMATION

1. Do you currently receive medication assistance from LA HAP? ☐ Yes ☐ No ☐ Unsure

2. Are you currently taking prescription medications? ☐ Yes. **Skip** to question 5. ☐ No

3. If you are prescribed medications but are not taking them, what is the last date you took your medications?

Month: _____ Year: _____ ☐ I have never taken medications. **Skip** to question 5.

4. Why did you stop taking your medications? **(this will not affect your eligibility)**

5. Is there anything else you would like to tell us about your medication situation that could help clarify your application?

STEP 13: ADDITIONAL COMMENTS

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

STEP 14: CLIENT RESPONSIBILITIES AND RELEASE OF CONSENT

By signing below I confirm that I understand the following:

- Falsification of information may lead to suspension or termination of services through LA HAP.
- It is my responsibility to provide LA HAP with my medical status, income, and Louisiana residence every six months.
- It is my responsibility to notify LA HAP of any changes in my contact information, income, residence, or insurance status.
- Failure to provide the necessary documentation could jeopardize my approved assistance through LA HAP.
- LA HAP can only provide services for as long as funds are available, my enrollment is active, and my eligibility is confirmed.
- Approval for LA HAP does not change the mailing address on file with my insurance/third party payer.
- **Information about my insurance/third party payer, including billing, premium and benefit notices will continue to be mailed to me and it is my responsibility to forward that information to LA HAP.**
- My information is being entered into a statewide electronic database accessible by other Louisiana agencies from which I receive Ryan White services.
- I request a third party payer to pay any authorized benefits to LA HAP on my behalf.
- LA HAP agrees to treat all information as confidential.
- I hereby give my consent to LA HAP to obtain, verify, and/or release my demographic, medical, prescription, and/or insurance coverage information, with other entities as necessary to effectively manage my medication access.
- Information may be shared with but is not limited to the following: physician, health department personnel, treatment center personnel, pharmacy services provider, referral source, clinic, insurance broker and/or insurance carrier, Medicare, Medicaid, CCIIO, CMS, SSA, SSDI, and other Louisiana agencies from which I receive Ryan White services.
- Ryan White funds are funds of last resort and I must apply for other assistance for which I may be eligible, including, but not limited to Medicaid. Medicare, insurance, and Social Security benefits.
- **Any refunds received from my insurance company/third party payer, for services rendered by LA HAP MUST be surrendered immediately to LA HAP. Failure to do so will result in disqualification from Ryan White services and constitutes fraudulent misuse of federal funding.**
- By providing my email address, I am consenting to receive emails regarding my LA HAP application, enrollment, and services. All emails will be sent by LA HAP via an encrypted email service. I acknowledge that commonly used email services are not secure and that I am responsible for ensuring the security of my personal email.
- This consent will remain in effect as long as I/my dependent remain eligible for services through LA HAP or until I withdraw it.

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)

STEP 15: PROVIDER (case manager, social service staff, etc.) INFORMATION (if applicable)

Signature of Provider

Date Signed

PRINT First and Last Name of Provider

Provider Entity/Agency Name

Provider Phone Number and Extension

STEP 16: APPLICATION CHECKLIST

In order to process your application in a timely manner, it is important that the application is complete. If your application is not complete, there may be a delay in obtaining your medication**. DID YOU…**

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

☐ Write an explanation of why your proof of residency does not match the address on page 1, if applicable?

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

☐ Sign and date the application?