

**ELIGIBILITY RECERTIFICATION FORM  
FOR  
HEALTH INSURANCE CONTINUATION PROGRAM (HICP)**

**I. PATIENT INFORMATION**

<b>LAST NAME</b>	<b>FIRST NAME</b>	<b>MIDDLE INITIAL</b>	<b>MAIDEN</b>
<b>ADDRESS</b>	<b>CITY AND STATE</b>	<b>ZIP CODE</b>	
<b>MAILING ADDRESS</b>	<b>CITY AND STATE</b>	<b>ZIP CODE</b>	
<b>DATE OF BIRTH</b>  ____/____/____	<b>SOCIAL SECURITY #</b>  --  --	<b>GENDER</b> <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> TRANSGENDER <input type="checkbox"/> UNKNOWN	<b>TELEPHONE NUMBER</b>  #1 (     )     - #2 (     )     -
<b>ETHNICITY</b> <input type="checkbox"/> HISPANIC <input type="checkbox"/> NON-HISPANIC <input type="checkbox"/> UNKNOWN	<b>RACE</b> <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	<b>MARITAL STATUS</b> <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED	

**II. CLINICAL INFORMATION**

<p style="text-align: center;"><b>DIAGNOSIS</b></p> <input type="checkbox"/> AIDS DATE: ____/____/____ <input type="checkbox"/> HIV POSITIVE DATE: ____/____/____	<p style="text-align: center;"><b>CD4</b></p> CURRENT: ____ DATE: ____/____/____ LOWEST: ____ DATE: ____/____/____ <hr/> <p style="text-align: center;"><b>VIRAL LOAD</b></p> CURRENT: ____ DATE: ____/____/____ HIGHEST: ____ DATE: ____/____/____
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<b>PHYSICIAN INFORMATION</b>			
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).

<input type="checkbox"/> MEDICAID	MEDICAID #:
<input type="checkbox"/> MEDICAID SPENDDOWN (QMB)	
<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:

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**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.**

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

**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?** \_\_\_\_\_

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**V. APPLICANT AGREEMENT**

I fully understand that the Health Insurance Continuation Program is intended for clients with HIV infection who are unable to pay for their health insurance premiums. I hereby certify that the information supplied in this application, and accompanying attachments, is complete and accurate. I fully understand that I am responsible for completing the recertification process, every 6 months, in order to continue to receive HICP services. If I fail to comply with this policy, I fully understand that I can be removed from HICP.

Furthermore, I hereby authorize the release of medical information, including information about my HIV status, to the Georgia Department of Human Resources, Division of Public Health, HIV Section.

\_\_\_\_\_ /\_\_\_\_\_/\_\_\_\_\_  
Print Client Name Date

\_\_\_\_\_  
Client Signature

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

\_\_\_\_\_ Date

\_\_\_\_\_ ( ) -  
Case Manager Signature Case Manager Phone Number

\_\_\_\_\_ ( ) -  
COMMENTS: Case Manager Fax Number

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# ELIGIBILITY RECERTIFICATION FORM FOR HEALTH INSURANCE CONTINUATION PROGRAM (HICP)

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 VA BENEFITS <input type="checkbox"/> CLIENT HAS OTHER PAYOR SOURCE _____ <input type="checkbox"/> INCOMPLETE APPLICATION* <input type="checkbox"/> Waiting List  <input type="checkbox"/> APPROVED <input type="checkbox"/> NOT APPROVED
	_____ REVIEWED BY
	____/____/_____ *DATE RETURNED TO ENROLLING AGENCY