FOR AICP OFFICE USE ONLY: AICP #:

AIDS INSURANCE CONTINUATION PROGRAM APPLICANT DATA COLLECTION FORM

Assurance of Confidentiality

All information that you provide on this data collection form or for the completion of the enrollment criteria will be kept strictly confidential to the fullest extent allowable by law. The data collected will be in aggregate form only and the identity of any applicants will not be revealed under any circumstances. **THE FOLLOWING INFORMATION IS REQUIRED FROM ALL POTENTIAL PARTICIPANTS. ALL SPACES MUST BE FILLED IN. IF THE QUESTION DOES NOT APPLY, STATE "N/A" IN THE SPACE PROVIDED. INCOMPLETE APPLICATIONS WILL BE RETURNED. PLEASE PRINT OR TYPE:**

DEMOGRAPHIC INFORMATION

First Name: ______________________________ Last Name: __________________________________

Social Security Number: ____________________________ Gender: ☐ Male ☐ Female ☐ Transgender

Date of Birth: ________________________ Age: __________ URN (optional): ____________________________

Race: ☐ White ☐ Black ☐ Native American ☐ Asian ☐ Pacific Islander ☐ Multiracial

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

CONTACT INFORMATION:

Secure Home Address: ____ Apt. #: _____________
Number and Street

____ Zip: ______________
City and State

Secure Mail Address: ____ Apt. #: ____________
(if different) Number and Street

____ Zip: ______________
City and State

Secure Phone Number: ____

HEALTH INSURANCE INFORMATION: **A COPY OF BOTH SIDES OF YOUR INSURANCE CARD, AND THE PREMIUM PAYMENT COUPON MUST BE ATTACHED.**

Insurance Company Name: ____

Policy Number: ____

Insurance Type: ☐ COBRA ☐ Group ☐ Individual ☐ Private Medication Supplement Policy

Policy type? ☐ HMO ☐ PPO ☐ POS ☐ Traditional (Indemnity)

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If COBRA: when will your coverage end? ______________________________

If Group: Group name ______________________________________ Policy number ___________________________

For COBRA & Group Policies: Federal Employee Identification Number (FEIN) _________________________________

Is this a Family policy? ☐ Yes ☐ No

Does your policy cover your prescriptions? (If yes include proof with application) ☐ Yes ☐ No

If no, how do you get your medications? ☐ ADAP ☐ Medicaid ☐ Compassionate Use ☐ VA ☐ Other

Premium amount: $_________________

Premium is paid: ☐ Weekly ☐ 2 Weeks ☐ Monthly ☐ 2 Months ☐ 3 Months ☐ 6 Months

Do you have Medicaid? ☐ Yes ☐ No

FEDERAL POVERTY LEVEL:

Total monthly income: ☐ 0 - 100% FPL

☐ 150% FPL ☐ 200% FPL ☐ 250% FPL

☐ 300% FPL ☐ 350% FPL ☐ 400% FPL

I declare that all statements made on this data collection form are true and complete to the best of my knowledge and I REALIZE THAT WILLFUL FALSIFICATION OF THIS INFORMATION BY ME MAY SUBJECT ME TO IMMEDIATE DISQUALIFICATION FOR PARTICIPATION IN THE AICP. I ALSO UNDERSTAND THAT IF I QUALIFY FOR PARTICIPATION, THE AICP MAY STOP PAYING MY INSURANCE PREMIUMS IF FUNDING FOR THIS PROJECT RUNS OUT, IS DISCONTINUED OR MY INSURANCE POLICY EXPIRES. Furthermore, I understand that it is MY RESPONSIBILITY TO SUPPLY THE COMMUNITY BASED ORGANIZATION WITH THE PREMIUM NOTICES I receive from my insurance company, thus ensuring that they are aware of my premium due date. I release this complete applicant data form to the Health Council of South Florida, Inc. for enrollment determination and data collection.

____ ______________________

Applicant's Signature Date

EFFECTIVE MAY 2009