

Reviewer's Initials _____
 Date Complete Application Received: _____
 Application Type: New Enrollment / Recertification / Returning

Data Entry's Initials _____
 Date of Application Determination: _____
 Application Determination: Approved / Denied

LOUISIANA HEALTH ACCESS PROGRAM (LA HAP) APPLICATION: RAPID START

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. **Income documentation is NOT required.**

SECTION 1: GENERAL ELIGIBILITY INFORMATION

1. Please check to indicate that the following are true. **ALL** must be true in order to be approved for expedited medication services.
- I have been diagnosed with HIV in the last 30 days.
- I understand that with this application, I am applying for LA HAP assistance with a 30 day supply of HIV medications ONLY.
- If my household income is between 0-138% of the FPIG and I am not Medicare eligible, I will apply for Medicaid.
- I understand that this there will be no extensions of my 30-day eligibility and I must complete the full LA HAP application if I wish to continue services after these 30 days.

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? <input type="checkbox"/> Yes <input type="checkbox"/> 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) <input type="checkbox"/> I do not have a SSN		
9. Language Preference (if not English)	10. Are you currently homeless? (residential address and mailing address still required) <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes. Send mail and my card to my residential address. Skip to question 22. <input type="checkbox"/> 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 <input type="checkbox"/> No primary phone (____)____-_____	May LA HAP contact you at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No	May LA HAP leave a voicemail at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No	May LA HAP text you at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No
23. Secondary Phone <input type="checkbox"/> No secondary phone (____)____-_____	May LA HAP contact you at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No	May LA HAP leave a voicemail at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No	May LA HAP text you at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Do you have a friend or family member (alternate contact) that LA HAP may speak to about your application on your behalf? <input type="checkbox"/> Yes. Fill in your alternate contact's information in questions 26-28. <input type="checkbox"/> No. Skip to SECTION 3.			
26. Alternate Contact's Name	27. Relationship to you	28. Phone Number	

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

SECTION 4: INSURANCE INFORMATION

1. Do you have any form of health insurance with prescription drug coverage?
 Yes (Marketplace, employer sponsored) Yes (Medicare) No.

SECTION 5: 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 6: 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 let LA HAP know anytime my contact/mailling 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/mailling 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.

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)