DUE ____________

Illinois Department of Public Health
HIV/AIDS Section
Continuation of Health Insurance Coverage Program (CHIC) Application

APPLICANT INFORMATION		
Last Name:	**First Name:**	**Middle Initial:**
Social Security Number:	**Date of Birth:**	**Phone Number:** ( ) -
Address: **Apartment/Floor:**	**City:**	**State:**
Zip Code:	**E-mail Address:**	**County:**
________ **Male** ________ **Female**		
Marital Status: ____Single ____Married ____Widowed ____Divorced		
Race/Ethnicity: ____White ____Black ____Hispanic ___Other (Specify)		

Diagnosed with HIV/AIDS: _____Yes _____No **CD4 Count:** ____________ **Viral load:** ________________
(Attach latest CD4 or viral load test within past 12 months.) Lab results may be faxed by your doctor to 217- 785-8013.

INCOME AND ASSET INFORMATION

The number of persons in my household, including myself, for which I am responsible, is ____________.

How much do you, your spouse and, if applicable, dependent children who live with you make per month before taxes are taken out? Include all earned and unearned income (such as SSI, SSDI, unemployment, dividends and interest income).

$________________________ gross per month

(Please provide proof of income; such as copy of 2 most recent pay stubs or unemployment checks, disability award letter or income tax form. If you have no income, please complete the Confirmation of Support letter.)

Do you have any of the following?

Bank savings account? _____Yes _____No Current Balance $__________________________

Stocks or Bonds? _____Yes _____No Value $__________________________________

A **second** vehicle? _____Yes _____No Make__________________ Year______________
Estimated Book Value: $_________________________ How much do you owe? $____________________

A **second** home or other property? _______Yes ______ No
Estimated appraised value $______________ If sold, how much would you receive? $____________________

Total value of all income and assets $____

INSURANCE INFORMATION		
Type of Insurance Policy: (Check all that apply) **COBRA__________ Group__________ Individual__________**		
If COBRA: Start Date of coverage:___________________ End Date of coverage:_________________		
Type of Coverage: Individual_____ Family_____ (List all members covered; attach additional sheet if necessary.)		
Name:	**Name:**	**Name:**
Relation:	**Relation:**	**Relation:**
SSN:	**SSN:**	**SSN:**
Date of Birth:	**Date of Birth:**	**Date of Birth:**

POLICY INFORMATION
Insurance Company Name: (Attach Proof of Insurance: insurance card, COBRA election form, recent payment due notice)
Employer Group Name: **Policy Number:**
Policyholder's Name:
Amount of Premium: $______________________ **Next Payment Due Date:________________________** **Paid: Monthly__________ Quarterly__________ Annually__________** (check the one that applies)
Premium paid to: Name:____ Address:____ City:_________________________ State:____________ Zip Code:___________________ Telephone: ( )
What is the amount or percentage of coverage for prescription drugs: (Example: 80/20% coverage or $25 co-pay)
What, if any, is the maximum benefit cap on your insurance?
What, if any, is the deductible that you must meet before insurance will provide coverage?

Please provide your Case Manager or person who may be contacted for additional information if you are not available.

Case Manager or Contact Person: ____________________________________Telephone: (______) _________________

Clinic/Agency or Address: ____

City: __________________________________ State: _____________ Zip Code___________________

Is this person aware of your HIV status? ________Yes ________No

By signing this application, I hereby swear that all information I have provided is true to the best of my knowledge. I agree to notify the Illinois Department of Public Health 800-825-3518 (in Illinois only) or 217-524-5983, TTY 800-547-0466 (for hearing impaired use only) of any change in insurance premiums, policy type, residence or other factors that may affect my eligibility for the Program. By signing this certification, I authorize the health insurer/employer listed on this form to disclose all insurance information to the Illinois Department of Public Health for the purpose of facilitating payments under this program. I further authorize the Illinois Department of Public Health to recoup any monies, subject to notice and hearing that were incorrectly paid on my behalf.

Signature: ____ Date: ________________________________

NOTE: You must reapply every six (6) months or it could be grounds for dismissal from the program.

ILLINOIS DEPT. OF PUBLIC HEALTH

CONFIRMATION OF SUPPORT LETTER

Date: ______________________

Name of Applicant: _______________________________________

Social Security Number: _________-_____-_________ Date of Birth: ________________________

If you are being supported with room and board, please have the person(s) providing that support verify the information below with a signature.

I/We, ____, have been the sole support for the person named above and, to the best of my/our knowledge, declare that this person has no other primary means of support. I/We have provided support since ________________________________.

____
Provider's Signature

____
Relation to Applicant

____
Provider's Address

____
Telephone Number

____
Applicant's Signature

____
Case Manager's Signature

***NOTE*:**

IF applicant has no means of support, please write a brief summary noting the current living conditions/arrangements that apply in the space below:

Authorization to Release Confidential Information

Name: ____ [Please Print]

Social Security Number: ____ [Please Print]

Date of Birth: ____ [Please Print]

As a client enrolled in the Continuation of Health Insurance Coverage (CHIC) Program, I hereby acknowledge that information related to my client record is deemed confidential and may only be released upon my written consent.

By signing this authorization, I ____ authorize the written release of my confidential information to the Illinois Department of Public Health- Continuation of Health Insurance Coverage (CHIC) Program or Illinois Public Health Association (IPHA), the department's contracted representative, for the purposes outline below.

Purposes of Release:

1. **To protect your individually identifiable health information transmitted or maintained in any form or medium…oral communications, paper records, and electronic records… (*Protecting Health Information Privacy and Complying with Federal HIPAA Regulations, 2004*)**.
2. **To verify the begin date and end date of service for your COBRA coverage.**
3. **To ensure timely premium payments.**
4. **To obtain information concerning changes with your COBRA and/or Insurance coverage.**
5. **To ensure that all possible benefits are being maximized by the client.**

I recognize that this release is effective for one year from the date I sign this form; moreover, this signed document will assist, more efficiently, in the coordination of CHIC Services.

I understand that I do not have to consent to the release of this information. I also accept that my Social Security number (if disclosed) will be used only for the sole purpose of serving as a unique identifier for the eligibility with the Department's contracted entity. You are not required to disclose your Social Security number and no rights, benefits, or privileges will be denied if you choose not to disclose it.

____ _____________________ (Date)
Client Signature (age 18 and older)

____ _____________________ (Date)
Parent/Guardian if under 18 or
legally disabled (court-appointed guardian)

____ ______________________ (Date)
Witness