EARLY INTERVENTION PROGRAM (EIP) CONFIDENTIAL APPLICATION

PO Box 47841, Olympia, WA, 98504 Toll Free Phone – 1-877-376-9316 Fax – 360-664-2216

You must answer **all** questions and include **all** required documents. If **all** required documents are not included, the application is incomplete. Submission of an incomplete application will result in your eligibility determination being delayed and may result in your application being denied.

EIP Client ID Number

1. PATIENT INFORMATION

Legal Last Name	**Legal First Name**	**M.I.**	**Social Security Number**

Marital Status

❑ Single ❑ Married ❑ Divorced ❑ Legally Separated ❑ Widowed ❑ Registered Domestic Partner (RDP)

Date of Birth (mm/dd/yyyy)	**Current Gender Identity**
	❑ Male ❑ Female ❑ Transgender – Male to Female ❑ Transgender – Female to Male

Sex Assigned at Birth	**Preferred Written Communications**	**Are you a Veteran?**
❑ Male ❑ Female	❑ English ❑ Spanish	❑ Yes ❑ No

Ethnicity	**Race** (select all that apply)
❑ Non-Hispanic ❑ Hispanic/Latino (a) ❑ Mexican, Mexican American, Chicano/a ❑ Puerto Rican ❑ Cuban ❑ Other Hispanic, Latino/a or Spanish origin	❑ White ❑ Black or African American ❑ American Indian/Alaska Native ❑ Asian ❑ Asian Indian ❑ Chinese ❑ Filipino ❑ Japanese ❑ Korean ❑ Vietnamese ❑ Other ❑ Native Hawaiian/Pacific Islander ❑ Native Hawaiian ❑ Guamanian or Chamorro ❑ Samoan ❑ Other Pacific Islander

2. RESIDENCY ADDRESS INFORMATION

What is your current housing situation?

❑ Home/Apartment You Own/Rent ❑ DOC Work Release Facility

❑ Long Term Care Facility ❑ Jail/Prison

❑ **No Home Address Declaration** - If you do not have a home address, complete the following statement:

I do not have a home address. Last night I stayed:

❑ at a park ❑ in a car ❑ at a shelter ❒ on the street ❑ with family/friend ❑ somewhere else

In the city of: _____.

Primary Phone	**Secondary Phone**	**Okay to Leave Voice Mail?**
		❑ Yes ❑ No

Street Address	**Apt / Lot / Floor**	**County**

City	**State**	**ZIP Code**

3. MAILING ADDRESS

Is your mailing address the same as your residence? ❑ Yes ❑ No

Street Address (only required if different from your residence address or have no home address)	**Apt / Lot / Floor**

County	**City**	**State**	**ZIP Code**

4. ELECTRONIC MESSAGING

Okay to send email? ❑ Yes ❑ No	**Okay to send text messages?** ❑ Yes ❑ No
Email: _____	**Cell Phone with Area Code:** _____ **Cell Phone Carrier:** _____

5. HOUSEHOLD MEMBERS

Enter total number of household members	**#** _____

Please complete the section below to document each household member.
If more pages are needed, you may copy this page.

Household Member - Applicant

Last Name	**First Name**	**Are you currently an EIP Client?**	
		❑ Yes ❑ No	
	Relationship to Client (Spouse, RDP, Child, some other person you are able to claim on your taxes)	**Date of Birth**	**Do you currently have income?**
	SELF		❑ Yes ❑ No

Household Member 2

Last Name	**First Name**	**Is this person currently an EIP Client?**	
		❑ Yes ❑ No	
Okay to contact?	**Relationship to Client** (Spouse, RDP, Child, some other person you are able to claim on your taxes)	**Date of Birth**	**Does this person currently have income?**
❑ Yes ❑ No			❑ Yes ❑ No

Household Member 3

Last Name	**First Name**	**Is this person currently an EIP Client?**	
		❑ Yes ❑ No	
Okay to contact?	**Relationship to Client** (Spouse, RDP, Child, some other person you are able to claim on your taxes)	**Date of Birth**	**Does this person currently have income?**
❑ Yes ❑ No			❑ Yes ❑ No

Household Member 4

Last Name	**First Name**	**Is this person currently an EIP Client?**	
		❑ Yes ❑ No	
Okay to contact?	**Relationship to Client** (Spouse, RDP, Child, some other person you are able to claim on your taxes)	**Date of Birth**	**Does this person currently have income?**
❑ Yes ❑ No			❑ Yes ❑ No

6. HOUSEHOLD INCOME INFORMATION

If you and your household do not have income, proceed to the No Income Declaration at the bottom of the page.
Please include **all** required income documentation. (See help guide for types of acceptable income documentation)

Current Monthly Household Income	Who Receives This Income	Monthly Gross $
Wages, salaries, tips, etc.		
Taxable interest		
Tax-exempt Interest		
Ordinary Dividends		
Exempt interest Dividends		
Taxable refunds of state/local income taxes		
Alimony or Other Spousal Support Received		
Business or Self Employed income/loss (Schedule C or C-EZ)		
Capital gain/loss (Schedule D)		
Other gains/losses		
IRA distributions -taxable amount		
Pensions and Annuities		
Rental real estate, trust (Schedule E)		
Farm income/loss (Schedule F)		
Unemployment Income		
Retirement Income from Social Security		
Social Security Disability (SSDI)		
Supplemental Social Security Income (SSI)		
Other Client Income (Jury Duty Pay, Gambling Winnings)		
Child Support, Workman's Compensation, or Monetary Gift		

Current Monthly Household Income Adjustments		
MAGI Income Deductions	**Who Receives This Deduction**	**Monthly Amount $**
Educator Expenses		
Business Expenses		
Health Saving Account		
Moving Expenses		
Deductible part of Self-Employment Tax (Schedule SE)		
Self-Employment Health Insurance Deduction		
Self-Employment SEP, SIMPLE plans		
Penalty on Early withdrawal of saving		
Alimony paid		
IRA Deduction		
Student loan interest deduction		
Tuition and Fees		
Domestic Production Activities		

Did You File a Tax Return?	❑ Yes	❑ No

No Income Declaration

❑ By checking this box, I declare my household and I do not have any income. I understand that EIP may ask for documentation from my previous employer or benefit termination letters at any time. I also understand that I will inform EIP of any income changes within 20 days of the change. If I give EIP untruthful or incomplete information, EIP may deny my eligibility and I may have to pay for services I received if I was not eligible for them.

7. HEALTH INSURANCE INFORMATION (if more pages are needed, you may copy this page)

Do you have health insurance? ❑ Yes ❑ No	If **yes**, you must provide a copy of all insurance cards and check the type of insurance that applies to you. If **no**, does your employer offer insurance? Please tell us when you will be eligible: _____ _____

Health Insurance #1

Status	**Would you like assistance paying the monthly premium?**
❑ Active ❑ Applied	❑ Yes (See EHIP Enrollment form) ❑ No

Type of coverage?

Medicare: ❑ Medicare Part A Only ❑ Medicare Part A & B ❑ Medicare Part C (MAPD) ❑ Medicare Part D (PDP)

Insurance: ❑ Marketplace (Qualified Health Plan) ❑ Employer ❑ Individual

❑ Check if you have VA benefits — Do you receive your HIV Care at the VA? ❑ Yes ❑ No
❑ Check if you have Indian Health Services — Do you receive your HIV Care at IHS? ❑ Yes ❑ No

Insurance Company Name	**Policy/Plan Name**

Effective Date	**Is Prescription Coverage Included?**	**Is Medical Coverage Included?**
	❑ Yes ❑ No	❑ Yes ❑ No

Health Insurance #2 (If Applicable)

Status	**Would you like assistance paying the monthly premium?**
❑ Active ❑ Applied	❑ Yes (See EHIP Enrollment form) ❑ No

Type of coverage?

Medicare: ❑ Medicare Part A Only ❑ Medicare Part A & B ❑ Medicare Part C (MAPD) ❑ Medicare Part D (PDP)

Insurance: ❑ Marketplace (Qualified Health Plan) ❑ Employer ❑ Individual

❑ Check if you have VA benefits — Do you receive your HIV Care at the VA? ❑ Yes ❑ No
❑ Check if you have Indian Health Services — Do you receive your HIV Care at IHS? ❑ Yes ❑ No

Insurance Company Name	**Policy/Plan Name**

Effective Date	**Is Prescription Coverage Included?**	**Is Medical Coverage Included?**
	❑ Yes ❑ No	❑ Yes ❑ No

Dental Insurance

Do you have dental insurance?	**Insurance Company Name**
❑ Yes ❑ No	

8. MEDICAL INFORMATION

Are you currently prescribed antiretrovirals? ❑ Yes ❑ No			
HIV Care Physician			
Last Name	**First Name**	**Phone Number**	
Address	**City**	**State**	**Zip Code**
HIV Care Facility			
Facility Name		**Phone Number**	
Address	**City**	**State**	**Zip Code**

9. AUTHORIZED REPRESENTATIVE INFORMATION

Please provide the following information for any person you would like us to talk to about your EIP coverage. The Date of Birth for your authorized representative(s) is used to verify the person's identity when speaking about your coverage.

Authorized Representative #1		
Last Name	**First Name**	
Phone Number	**Okay to contact?**	**Date of Birth**
	❑ Yes ❑ No	

Authorized Representative #2		
Last Name	**First Name**	
Phone Number	**Okay to contact?**	**Date of Birth**
	❑ Yes ❑ No	

Authorized Representative #3		
Last Name	**First Name**	
Phone Number	**Okay to contact?**	**Date of Birth**
	❑ Yes ❑ No	

HIV Medical Case Manager	
Case Manager Name	**Agency**
Phone Number	**Email**

10. SIGNATURE PAGE: AGREEMENT, RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

The following agencies coordinate and verify eligibility for all applicable services, as well as treatment and care coordination with other programs related to EIP. They all adhere to the same confidentiality requirements listed below:

- Pharmacy Benefits Manager/Ramsell Corporation • Insurance Benefits Manager/Evergreen Health Insurance Program (EHIP)
- WA State Department of Employment Security (Income Verification Services) • WA State Department of Social and Health Services (Medicaid Verification)
- WA State Health Care Authority (Apple Health) • All EIP contracted Providers • System Software Vendor

By signing this document, I agree that I have read this application, certify that the information in this application is true and accurate to the best of my knowledge, and understand the following:

I have the right to:

1. Be treated with respect, consideration and honesty.
2. Receive services without discrimination on the basis of race, color, sex/gender, ethnicity, national origin, religion, age, class, or sexual orientation, as well as physical or mental ability.
3. Have my records be treated as confidential.
4. File an appeal about eligibility and coverage decisions.

I have the responsibility to:

1. Treat Department of Health staff and contracted service partners with respect, consideration and honesty.
2. Give correct, current, and complete information.
3. Respond to the Programs request(s) for information.
4. Reimburse the Program for any and all premium or benefit reimbursement payments that are paid to me in error during my enrollment.
5. Reimburse the Program if premiums are paid on my behalf for excess advance premium tax credit received as part of an Income Tax refund, if applicable.
6. File income tax forms, if applicable.
7. Update my income in the WA Healthplanfinder and with EIP if I have a Qualified Health Plan through WA Health Benefits Exchange.
8. Notify the Program, or have my Case Manager notify the Program, of any changes that affect my eligibility within 20 days. These changes include, but are not limited to: income, address, family size and health insurance coverage.
9. Apply for other services for which I may be eligible before I receive services from EIP.
10. Submit information regarding my continued eligibility for participation in the Program(s), including proof of income, proof of residency, availability of health insurance coverage, and an updated and signed version of this form with my recertification application every (6 months) as per Federal Guidelines.

I understand that:

1. The information requested on this application is for the purpose of determining my eligibility for state and federally funded services.
2. The funding is limited and may expire at any time without extended or alternate funds being available.
3. The Program will use other state and federal data systems as well as other information to verify the information I give them.
4. Upon approval, my eligibility will expire after six months. Before the conclusion of those six months, I will be required to reapply and provide updated eligibility information to continue receiving services.
5. I may have to pay a fee, called a cost share, to receive Program services.
6. If I am considered eligible for services, my information may be utilized by our contractual partners to provide Program services.
7. Eligibility approval does not mean I will receive or be enrolled in all available services. I understand each service may require additional information, and that I must provide this information for verification before enrollment into said services.
8. If I am approved for premium assistance:
   a. I will need to select EHIP as my Sponsorship Representative for a Qualified Health Plan in the WA Healthplanfinder, if applicable. By selecting EHIP as my sponsor, I authorize EHIP to communicate and share information with the WA Healthplanfinder.
   b. I must notify the Program & EHIP of any changes to my insurance coverage such as:
      i. Receiving insurance from my job, Medicaid, Medicare, partner, spouse or other source(s).
      ii. Receiving a premium statement, premium coupon or coupon book.
      iii. Receiving a late premium notice, letter or phone call.
      iv. Receiving a premium change notice or letter.
   c. I give the Program & EHIP authorization to communicate and share information about my Qualified Health Plan (QHP), Healthcare for Workers with Disabilities (HWD), Medicare Part D (PDP) or Employer Sponsored Insurance (ESI) through myself, my parent(s), my partner, my spouse's employer.
   d. I authorize and direct my health insurer to directly reimburse the Program for any unused premium payments should my insurance policy terminate or be cancelled for any reason, including but not limited to future ineligibility, voluntary termination, involuntary cancelation, termination by operation of law, or death.
   e. If I want to revoke this authorization and terminate the agreement, I must do so in writing to both insurance benefits manager and the health plan administrator.

Release of Information: I give my permission for the program to share information from this application and from subsequent documentation obtained by the program with contracted partners, case managers, and the family/friends I listed in the Authorized Representative section of this application. I give this permission for one year and 60 days from the date I sign this authorization.

Assignment of Benefits: I hereby assign to the State of Washington Department of Health any right to drug or medical benefits to which I may be entitled under any other plan of assistance or insurance from any other liable third party. I consent to the assignment of these benefits to Washington State Department of Health and I understand that the Washington State Department of Health is entitled to repayment for incorrectly provided benefits or benefits to which a third party is liable.

_____ _____

Applicant or Legal Guardian Signature **Do Not Leave Blank** Today's Date (mm/dd/yyyy) **Do Not Leave Blank**