For LA HAP Staff Use Only

Reviewer's Initials _____ Data Entry's Initials _____
Date Complete Application Received: _____ Date of Application Determination: _____
Application Type: New Enrollment / Recertification / Returning 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? ☐ Yes ☐ 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) ☐ I do not have a SSN

9. Language Preference (if not English)

10. Are you currently homeless? **(residential address and mailing address still required)** ☐ Yes ☐ 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? ☐ Yes. Send mail and my card to my residential address. **Skip** to question 22. ☐ 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 ☐ No primary phone
(_____)_____-_____
May LA HAP contact you at this number? ☐ Yes ☐ No
May LA HAP leave a voicemail at this number? ☐ Yes ☐ No
May LA HAP text you at this number? ☐ Yes ☐ No

23. Secondary Phone ☐ No secondary phone
(_____)_____-_____
May LA HAP contact you at this number? ☐ Yes ☐ No
May LA HAP leave a voicemail at this number? ☐ Yes ☐ No
May LA HAP text you at this number? ☐ Yes ☐ No

25. Do you have a friend or family member (alternate contact) that LA HAP may speak to about your application on your behalf?
☐ Yes. **Fill** in your alternate contact's information in questions 26-28. ☐ 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/mailing 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/mailing 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)