



# CONFIDENTIAL APPLICATION

Health insurance is often confusing. Our staff is happy to explain any of this information or help you fill out the forms in this packet. You can also talk to your case manager if you have one. Our phone number is 206-323-2834 in King County and 800-945-4256 statewide. You can also get more information about our program and download applications at [www.ehip.org](http://www.ehip.org).

## What does the Evergreen Health Insurance Program do?

Evergreen pays medical insurance premiums for eligible Washington residents. To be eligible for Evergreen, you must first enroll in Washington State's Early Intervention Program (EIP). You must also maintain your eligibility with EIP in order for Evergreen to be able to continue paying your insurance premiums.

If you are not currently enrolled in EIP, you can get an EIP application by calling EIP at 800-272-2437 or going to [http://www.doh.wa.gov/cfh/HIV\\_AIDS/Client\\_Svcs](http://www.doh.wa.gov/cfh/HIV_AIDS/Client_Svcs). Evergreen staff can provide you with an EIP application, and help you fill one out if you would like. Your case manager can also help you with this.

## What can Evergreen pay for?

Evergreen can pay for your current health insurance, or help you find insurance if you are not currently insured. Evergreen can pay for *medical* insurance premiums for COBRA coverage, group policies, and individual insurance, including the Washington State Health Insurance Pool (WSHIP). We can also pay for Medicare Drug Plans, including Prescription Drug Plans, and Medicare Advantage Plans that have prescription coverage. We can pay for Medicare part B *if* you receive a bill. We can only pay for *your* insurance (not your children or partner or spouse). We can only make payments to companies, not individuals.

## How do you apply?

1. Enroll in the Early Intervention Program if you are not currently enrolled.
2. Complete all sections of the Evergreen application (attached). Please use a pen and print neatly.
3. You must include copies of two forms of ID, such as a your WA State driver's license, WA State identification card, Social Security card, student ID, or passport. You can also use a lease agreement or utility invoice with your name and current address, voter registration card, social security award letter, or pay check or tax return showing your social security number.
4. You must include a copy of your insurance card and/or the insurance application or paperwork.
5. Mail (do not fax) your completed application and supporting paperwork to:

Evergreen Health Insurance Program  
1002 East Seneca  
Seattle, WA 98122

## How will Evergreen process your application?

We will mail you a confirmation letter when your application has been approved. A determination of eligibility will be made within two weeks of receiving a **completed** application. If your application is incomplete, we will contact you.

## What do you need to do if you are a current Evergreen client, but your insurance is changing?

You will need to fill out an application for each new insurance policy. If your HIV condition has not changed, you can skip Section 8. We need to have current information and releases for every policy we pay for.

## A note about confidentiality.

We will talk with your case manager and the staff of the Early Intervention Program about your eligibility. We will not talk to anyone else unless you give us permission. If you want us to share information with a partner, spouse, caregiver, or other family member, include their name in Section 6 of the application.



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| Section 1: Applicant Information |  |                        |        |   |
|----------------------------------|--|------------------------|--------|---|
| Last Name                        |  | First Name             |        | MI  |
| Street Address                   |  | City                   | County | State Zip   |
| Mailing Address (if different *) |  | City                   | County | State Zip   |
| Home Phone<br>( ) -              | Messages ok?<br><input type="checkbox"/> yes <input type="checkbox"/> no | Birth Date             |        | <input type="checkbox"/> Male <input type="checkbox"/> Female<br><input type="checkbox"/> Transgender |
| Other Phone<br>( ) -             | Messages ok?<br><input type="checkbox"/> yes <input type="checkbox"/> no | Social Security Number |        | Email Address   |
| Case Manager's Name              |  | Case Manager Agency    |        | Case Manager Phone<br>( ) -   |

\* If you would like your mail sent to your case manager **instead** of you, please write her or his address under "Mailing Address."

| Section 2: Household Information  |   |   |  |
|---|---|---|--|
| What are your current housing/living arrangements? Please check the appropriate box in <i>each</i> column.  |   |   |  |
| <input type="checkbox"/> Permanently housed<br><input type="checkbox"/> Non-permanently housed<br><input type="checkbox"/> Institution<br><input type="checkbox"/> Other<br><input type="checkbox"/> Homeless | <input type="checkbox"/> Rental<br><input type="checkbox"/> Own House<br><input type="checkbox"/> Other | <input type="checkbox"/> Single Adult, living alone<br><input type="checkbox"/> Partnered or Married<br><input type="checkbox"/> Living with Other Adults<br><input type="checkbox"/> Single Parent<br><input type="checkbox"/> Other | Household size: _____<br><br>Number of dependants: _____ |

| Section 3: Voluntary Information   |   |
|--|---|
| Please answer <i>both</i> questions 1 and 2. (These questions are for grant purposes only).  |   |
| 1. Please check all that apply to you:<br><input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American<br><input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other: _____ |   |
| 2. Are you Hispanic or Latino? <input type="checkbox"/> yes <input type="checkbox"/> no  |   |
| 3. Would you like to receive future information in Spanish?<br>¿Quiere recibir información en español en el futuro?  | <input type="checkbox"/> yes <input type="checkbox"/> no<br><input type="checkbox"/> sí <input type="checkbox"/> no |

Last revised 12/2006

**Section 4: Insurance Information**

Please provide the following information for the insurance policy we will be paying for. We need this information in order to pay your premiums. Include with your application the items listed in question 6 below AND:

- a copy of your insurance card, if you currently have coverage
- a copy of your Medicare card, if you have Medicare

If you do not currently have insurance and aren't sure what to do, please call EHIP at 1-800-945-4256 or 206-323-2834 now, or your case manager.

1. What is your Early Intervention Program (EIP) number? \_\_\_\_\_  
What are your dates of eligibility with EIP? \_\_\_\_\_ to \_\_\_\_\_  
*(This information is on your EIP award letter).*

2. Have you ever applied for Medicaid (medical coupons/DSHS)?  yes  no  
If yes: Month \_\_\_\_\_ Year \_\_\_\_\_ Do you have Medicaid now?  yes  no

3. Do you currently have health insurance?  yes  no  
Are you eligible for COBRA through your previous employer?  yes  no

4. Have you had insurance or Medicaid in the past 63 days?  yes  no

5. Do you currently have Medicare Part **A**?  yes  no  
Medicare Part **B**?  yes  no  
If you have Medicare, do you qualify for Extra Help?  yes  no  
*(Extra Help is also known as the Low Income Subsidy for Medicare Part D).*

6. What type of insurance coverage do you want us to pay for? *(Choose one.)*

- Medicare Part D -----> include a bill from the PDP when it arrives; we will need this bill to process your application
- Medicare Advantage -----> include a bill from the MA-DP when it arrives; we will need this bill to process your application
- Individual -----> include a bill from the insurance company
- Group -----> include a bill from the insurance company and contact info for the plan
- HWD -----> include a bill; you will need to send us bills every month
- Medicare Part B -----> include a bill from CMS; you will need to send us bills every quarter  
\* We can only pay for part B premiums if you receive a bill. If you SSI or SSDI, payments are automatically withdrawn and we are not able to reimburse individuals.
- Basic Health -----> include a bill and the plan name
- COBRA -----> include paperwork showing eligibility dates, a copy of your election form, and contact info (including the name & phone numbers below)  
**When is the effective date of the COBRA?** \_\_\_\_\_  
 COBRA Administrator? \_\_\_\_\_  
 Former Employer? \_\_\_\_\_
- WSHIP -----> include a completed WSHIP application, proof of residency that matches your application, and *please call us* to coordinate your application

7. REQUIRED: Does this plan cover at least 50% of prescriptions?  yes  no  
REQUIRED: Is there an annual cap on the amount that can be paid toward prescriptions?  
 yes  no  
REQUIRED: What is the annual deductible? \_\_\_\_\_

|   |      |                          |                    |     |
|---|------|--------------------------|--------------------|-----|
| 8. Please provide the following information <u>on the plan you want Evergreen to pay for:</u> |      |                          |                    |     |
| Insurance Company   |      | Plan Name                |                    |     |
| Who are the premium checks made out to?   |      |                          | Your Policy Number |     |
| Mailing Address (for premium)   | City | County                   | State              | Zip |
| Company Telephone Number  |      | Contact Person           |                    |     |
| Monthly Premium Amount  |      | Due Date of Next premium |                    |     |

|   |                          |
|---|--------------------------|
| <b>Section 5: Authorization To Represent &amp; Obtain Insurance Information (REQUIRED)</b>  |                          |
| <b>Client Name:</b> _____ <b>Date of Birth:</b> _____<br><b>Social Security or Subscriber ID number:</b> _____  |                          |
| <b>I. My Authorization</b> <ul style="list-style-type: none"> <li>The type of information to be released is only my premium payment and enrollment information.</li> <li>The name of the organization authorized to release my premium payment and enrollment information is: _____<br/> (Name of the insurance company / COBRA administrator we will be paying)</li> <li>You may disclose my premium payment and enrollment information to the Evergreen Health Insurance Program; 1002 E Seneca St; Seattle, WA 98122.</li> <li>The reason for this authorization is for the payment of my insurance premiums.</li> <li>This authorization ends six months after termination of benefits under the health and/or COBRA plan.</li> </ul> |                          |
| <b>II. My Rights</b> <ul style="list-style-type: none"> <li>I understand that I have the right to revoke this authorization at any time. I understand that I must revoke this Release of Information authorization in writing. I understand that to revoke this authorization I can either fill out a revocation form from the health plan or write a letter to the health plan.</li> <li>I understand that my premium payment information will be released to the Evergreen Health Insurance Program, which is subject to Federal Privacy Rules. I understand that information may not be protected if it is released to a person or organization that is not protected by Federal Privacy Rules.</li> </ul>                             |                          |
| _____   | _____                    |
| Signature of applicant or legally authorized individual   | Date                     |
| _____   | _____                    |
| Printed Name if signed on behalf of enrollee  | Relationship to enrollee |



**Section 8: HIV Condition Verification**

For grant purposes, we must track your HIV condition. The Applicant box must be filled out and signed by you, and the Documentation box must be filled out by your provider or case manager. **If you are a current Evergreen client whose insurance is changing, you can skip Section 8 unless your HIV condition has changed.**

**Applicant Authorization**

I authorize my health provider or case manager to inform the Evergreen Health Insurance Program about my HIV condition. I understand this documentation is required to apply for the Evergreen Health Insurance Program.

\_\_\_\_\_  
Signature of applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name

**Documentation**

The applicant named above is applying for assistance from the Evergreen Health Insurance Program. Please provide the following information.

Check the appropriate box:

- The applicant is HIV+, but does not have an AIDS diagnosis.
- The applicant has an AIDS diagnosis.

I have evidence to support this diagnosis, and I am the client's:

- Health Care Provider
- Case Manager

\_\_\_\_\_  
Signature of Health Care Provider or Case Manager  
(must be original signature)

\_\_\_\_\_  
Date

|                       |                       |                  |
|-----------------------|-----------------------|------------------|
| _____<br>Printed Name | _____<br>Phone Number | _____<br>Address |
|-----------------------|-----------------------|------------------|

**Application Checklist**

- Are you enrolled in the Early Intervention Program (EIP)?
- Are all five pages of the application filled out completely (pages 2-6 of this document)?
- Did you read and sign Sections 5, 6, and 7?
- Did you include copies of two forms of ID? (See the cover page for details on how to do this).
- Did you include a copy of your insurance card? Medicare card if you have Medicare?
- Did you include a copy of your insurance, Medicare or COBRA bill or application?
- If you are applying for WSHIP, did you include the "Denial of Coverage" letter and the "Score Sheet" from an insurance carrier? (Please call us for more information if you do not have these items yet).