



CONFIDENTIAL APPLICATION

What does the Evergreen Health Insurance Program do?

Evergreen pays medical insurance premiums for eligible Washington residents. To be eligible for Evergreen, you must be taking anti-retro viral medication. Additionally, you must enroll and maintain your eligibility in the Washington State's Early Intervention Program (EIP). EIP requires everyone enrolled in EIP to renew every year. If you fail to renew with EIP, Evergreen will not continue to pay your premiums.

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 *your* insurance (not your children or partner or spouse). We can only make payments to companies, not individuals. Evergreen can pay for the following types of insurance plans.

- COBRA
- Group plans
- Some individual insurance policies
- Washington State Health Insurance Pool (WSHIP)
- Medicare Prescription Drug Plans (PDP)
- Healthcare for Workers with Disabilities (HWD)
- Pre-existing Condition Insurance Plan (PCIP-WA)
- WA State Basic Health

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. Instructions are on the following page
3. You must include copies of two forms of ID. We will accept the following forms of identification:
 - WA State Driver's License
 - WA State Identification Card
 - Social Security Card
 - Birth Certificate
 - Tax return showing your social security number
 - Bank Statement
 - Passport
 - Lease agreement
 - Utility bill
 - Voter Registration
 - Pay stub showing your address
 - Student ID
4. You must include a copy of your insurance card and/or the insurance application or paperwork.
5. Mail your completed application and supporting paperwork to:

Evergreen Health Insurance Program
1002 East Seneca
Seattle, WA 98122

6. The Evergreen Health Insurance Program can accept time-sensitive faxed applications on a case-by-case basis. You must call the Insurance Advocate assigned to the application to obtain a one-time approval to fax an application.

How will Evergreen process your application?

We will mail you a confirmation letter when your application has been approved. Applications submitted with all required documentation are processed within two weeks. If your application is incomplete, we will contact you. Incomplete applications will be denied after 90 days.

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 5. 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.

Please use a pen and print neatly. Please be sure to complete all sections of the Evergreen Health Insurance Application. Any missing information will delay application processing time and may, in some cases, result in your application being denied.

Section 1: Applicant Information

Provide us with your personal information so we can communicate with you regarding your insurance. All of the information in this section is required. If you do not have a case manager, write N/A in this box. 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

Check each box that most closely matches your current living situation. Be sure to complete each box in this section.

Section 3: Voluntary Information

We strongly encourage you to complete this section as it helps us determine community and funding needs. Additionally, if you would like to receive communication in Spanish, please let us know in this section.

Section 4: Insurance Information

If you are not currently enrolled in the Early Intervention Program (EIP), you can get an EIP application by calling toll free at 877-376-9316 or going to *ehip.org* and follow the links to the Early Intervention Program. 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.

All the information in this section is required. First tell us about your current or previous insurance by answering questions one through five. Next, tell us about the insurance you would like us to pay on your behalf by answering questions six and seven. If you need help with any of these questions, please call us at 800-945-4256.

If you currently have insurance you must include a copy of your insurance card. Also, if you are on Medicare, you must provide us with a copy of your Medicare card.

Authorization to Obtain Insurance Premium Information

Complete and sign this section of the application. This allows us to communicate with your insurance company or COBRA administrator to pay premiums on your behalf.

Section 5: HIV Condition Verification

Sign and date the top half of the page. You will need to have your case manager or physician complete the bottom half of the page.

Section 6: Release of Information

This section is required and allows us to communicate with your case manager and the Early Intervention Program. If you would like us to be able to speak with a family member, spouse, friend, or significant other, you will need to add that person's name in this section.

Section 7: Applicant Agreement

You must sign and date the application, indicating that you understand your rights and responsibilities with the Evergreen Health Insurance Program.

Use this checklist to ensure that you have completed all the required sections of the application and provided the required documentation.

Application Checklist	
<input type="checkbox"/>	Are you enrolled in the Early Intervention Program (EIP)?
<input type="checkbox"/>	Are all five pages of the application filled out completely (pages 3-8 of this document)?
<input type="checkbox"/>	Did you complete and sign the Authorization to Obtain Insurance Premium Information?
<input type="checkbox"/>	Did you read and sign Sections 5, 6, and 7?
<input type="checkbox"/>	Did you include copies of two forms of ID? (See the cover page for details on how to do this).
<input type="checkbox"/>	Did you include a copy of your insurance card?
<input type="checkbox"/>	Did you include a copy of your Medicare card?
<input type="checkbox"/>	Did you include a copy of your insurance, Medicare or COBRA bill or 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 () -	Messages ok? <input type="checkbox"/> yes <input type="checkbox"/> no	Birth Date	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender	
Other Phone () -	Messages ok? <input type="checkbox"/> yes <input type="checkbox"/> no	Social Security Number	Email Address	
Case Manager's Name		Case Manager Agency	Case Manager Phone () -	
REQUIRED Have you used tobacco in the past 12 months? <i>(This includes chewing tobacco, cigarettes, snuff, and other forms of tobacco)</i>			<input type="checkbox"/> yes <input type="checkbox"/> no	

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 <input type="checkbox"/> Non-permanently housed <input type="checkbox"/> Institution <input type="checkbox"/> Homeless <input type="checkbox"/> Other	<input type="checkbox"/> Rental <input type="checkbox"/> Own House <input type="checkbox"/> Other	<input type="checkbox"/> Single Adult, living alone <input type="checkbox"/> Partnered or Married <input type="checkbox"/> Living with Other Adults <input type="checkbox"/> Single Parent <input type="checkbox"/> Other	Household size: _____ 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: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <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? ¿Quiere recibir información en español en el futuro?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> sí <input type="checkbox"/> no

Section 4: Insurance Information

Please provide the following information. We need this information in order to pay your premiums. Include these items with your application:

- a copy of your current 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, or your case manager.

1. What is your Early Intervention Program (EIP) number? _____
 What are your dates of eligibility with EIP? From _____ To _____
(This information is on your EIP award letter).
 If you just applied, when did you submit your application? ____/____/____
2. Do you have Medicaid now? yes no
 Have you ever applied for Medicaid (medical coupons/DSHS)? yes no
 If yes, when did you apply?: Month _____ Year _____
3. 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).
4. Do you currently have health insurance? yes no
 Date coverage began ____/____/____
 Date Pre-existing Wait Period Ends (if applicable) ____/____/____
5. Are you or your partner/spouse eligible for Group insurance? yes no
 Are you eligible for COBRA through your previous employer, or your partner/spouse's previous employer? yes no
6. Have you had Medicaid or any other insurance in the past six months? yes no
 If yes, provide the date coverage ended. ____/____/____

** Federal law requires companies with 20 or more employees who provide health insurance to offer continuing insurance coverage if you are no longer employed or if your hours are reduced.*

7. Please provide the following information on the plan you want Evergreen to pay for:

Insurance Company	Plan Name		
Who are the premium checks made out to?		Your Policy Number	
Mailing Address (for premium)	City	State	Zip
Company Telephone Number	Contact Person		
Monthly Premium Amount	Due Date of Next premium		

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

For any insurance plans below that you would like Evergreen to pay for, you **must** answer the following four questions. If you are unsure, refer to the Summary Plan Description.

1. What is the annual deductible? \$_____
2. Does this plan cover at least 50% of prescriptions? yes no
3. Is there an annual cap on the amount that can be paid toward prescriptions? yes no
4. Does this policy have dental coverage? yes no

<input type="checkbox"/> Medicare Part D Prescription Drug Plan ----->	Include a bill from the PDP when it arrives; we will need this bill to process your application
<input type="checkbox"/> Individual ----->	Include a bill from the insurance company
<input type="checkbox"/> Group ----->	Include a statement from your employer that includes the amount of the premium, who the check should be made out to, where it is to be mailed, and when it is due. You must include contact information for your employer in the previous section
<input type="checkbox"/> HWD ----->	Include a bill; you will need to send us bills every month
<input type="checkbox"/> Basic Health ----->	Include a bill and the plan name
<input type="checkbox"/> COBRA ----->	Include paperwork showing eligibility dates, a copy of your election form, and contact info (including the name & phone numbers in Section 6 on the previous page)
What was your last day of employment? _____ What date is on the COBRA notification _____	<input type="checkbox"/> COBRA Administrator _____ <input type="checkbox"/> Former Employer _____
<input type="checkbox"/> WSHIP ----->	Include a completed WSHIP application, proof of residency that matches your application, and <i>please call us</i> to coordinate your application. If you did not include a denial letter and score sheet, complete the following: What insurance company did you apply with? _____ When did you apply? ____/____/____
<input type="checkbox"/> PCIP-WA ----->	Include a completed PCIP-WA application and proof of residence. You must be a citizen or national, or person lawfully present in the United States and you must provide documentation of this. Please call us to coordinate your application.

Authorization to Obtain Insurance Premium Information (REQUIRED)

Client Name: _____ **Date of Birth:** _____

Social Security or Subscriber ID number: _____

I. My Authorization

I hereby authorize my insurance company / COBRA administrator (named below) to disclose my health information described below to the Evergreen Health Insurance Program

- The type of information to be released is only my premium payment, billing, and enrollment information.
- The name of the organization authorized to release my premium payment and enrollment information is:

(Name of the insurance company / COBRA administrator / employer we will be paying)

- You may disclose my premium payment and enrollment information to:

The Evergreen Health Insurance Program
1002 E Seneca Street
Seattle, WA 98122

- The reason for this authorization is for the payment of my insurance premiums.
- This authorization ends six months after termination of benefits under the insurance plan and/or COBRA plan.

Signature of applicant or legally authorized individual

Date

Printed Name if signed on behalf of applicant

Relationship to applicant

Section 5: HIV Condition Verification (REQUIRED)

For accounting purposes, we 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 5 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

REQUIRED

The applicant is on anti-retroviral therapy

- Yes
- No

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

Date

Printed Name

Address

Phone Number
(____) _____

Section 6: Release of Information (REQUIRED)

Evergreen Health Insurance Program keeps your records secure and confidential. To provide services to you, we must be able to share information with the Department of Health Early Intervention Program and your case manager.

I give my permission for the Evergreen Health Insurance Program and my health care providers, including the Early Intervention Program (EIP), physician, pharmacist, and my case manager, to share necessary information about my healthcare coverage in order to facilitate the management of my care. I give this permission from the date signed below until 60 days after I am no longer enrolled in the Evergreen Health Insurance Program. I understand I can revoke this authorization at anytime by writing a letter to the Evergreen Health Insurance Program.

Signature of applicant

Date

I also give permission for Evergreen to contact:

Name (of family member, caregiver, friend, etc.)

Phone Number

Relationship to you

Section 7: Applicant Agreement (REQUIRED)

II. My Responsibilities

- I understand that any premium reimbursement that is sent to me must be returned to Evergreen.
- I understand I must notify Evergreen of any changes to my insurance coverage or personal information, including:
 - If I get health insurance from my job, Medicaid, Medicare, partner, spouse, or any other source.
 - I get a premium statement, premium coupon, or coupon book.
 - I get a late premium notice or a letter or call that my premiums have changed.
 - I change my address or phone number.
 - My HIV Condition changes.

II. My Rights

- I understand that I have the right to revoke this authorization or terminate this agreement at any time. I understand that I must do so in writing to both Evergreen and the health plan administrator.
- I understand that my premium payment information will be released to the Evergreen Health Insurance Program, which is subject to Federal Privacy Rules. Information may not be protected if it is released to an entity that is not bound by Federal Privacy Rules.

The information on this form is true and complete to the best of my knowledge. I understand that giving false information is against the law. I also understand that if I give false or inaccurate information or fail to notify Evergreen of changes in a timely manner, **I may lose benefits and I may be required to pay back insurance premiums paid on my behalf.**

Signature of applicant

Date