



EARLY INTERVENTION PROGRAM (EIP)
CONFIDENTIAL APPLICATION

For Office Use Only

Do not use a pencil to complete this application. Print or type clearly.
You must answer all questions and include all required documents.
The application may be mailed to:
EIP at PO Box 47841, Olympia, WA, 98501 or faxed to 360-664-2216.

Submission of an incomplete application will result in your eligibility
determination being delayed and may result in your application being denied.

EIP ID:

SECTION 1: APPLICANT INFORMATION

Must Provide Proof of Legal Name

Legal Last Name: _____ Legal First Name: _____ M.I.: _____

Date of Birth: ____/____/____
MM / DD / YYYY

What Was Your Sex Assigned at Birth: [] Male [] Female

What is Your Current Gender Identity: [] Male [] Female

[] Transgender, Male to Female [] Transgender, Female to Male

Home Address

If you have a home address, complete the address field below and you -->
If you do not have a home address, complete the No Home Address Declaration.

Must Provide Proof of Washington Residency

Address: _____

Apartment/Unit #: _____

City: _____

State: WASHINGTON

ZIP: _____

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/friends, or [] somewhere else in the city of: _____.

Mailing Address [] Same as my home address above

Address: _____

Apartment/Unit #: _____

City: _____

State: _____

ZIP: _____

Phone: (____) _____-_____

May we leave a voicemail? [] Yes [] No

Email: _____ Would you like us to send you emails? [] Yes [] No

Would you like to receive documents from us in Spanish?

¿Quisiera usted recibir documentos de nosotros en español? [] Sí [] No

Social Security No.: _____-____-_____

OR

[] I do not have a Social Security No.

Citizen or Non-Citizen Status:

We do not share this information with anyone outside our program. Your citizenship status will not affect your eligibility with our program.

[] U.S. Citizen [] Lawfully Present Resident - Less than 5 Years

[] Lawfully Present Resident - More than 5 Years [] Other

Ethnicity

[] Non-Hispanic

[] Hispanic/Latino (a) (please specify)

[] Mexican, Mexican American, Chicano/a

[] Puerto Rican

[] Cuban

[] Other Hispanic, Latino/a or Spanish origin

Race (Choose all that apply)

[] White

[] Black or African American

[] American Indian/Alaska Native

[] Asian (select one or more):

[] Asian Indian [] Chinese [] Filipino [] Japanese [] Korean [] Vietnamese [] Other

[] Native Hawaiian/Pacific Islander (select one or more):

[] Native Hawaiian [] Guamanian or Chamorro [] Samoan [] Other Pacific Islander



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HIV Medical Case Manager

Case Manager Name: _____

Agency: _____

Phone Number: (____) _____ - _____

Email: _____

Family Information

Tell us about you and your family members who **live** with you. Attach another page if you need more space.

Name	Date of Birth	Relationship (Spouse, RDP, Child, some other person you are able to claim on taxes)	Is this person currently an EIP client?	Does this person currently have income?
		SELF	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

What is your marital status? Single, Divorced, Widowed Married – Living Together Married – Living Separately WA State Registered Domestic Partnership

Family Income (If you and your family do not have income, please proceed to the No Income Declaration)

Please check all types of income you and your family currently receive and provide the required documentation.

Income Type	Who Receives This Income	Required Documentation
<input type="checkbox"/> Work Income (Wages, Tips & Commissions)		Pay Stubs for the previous two months
<input type="checkbox"/> Railroad or Military Retirement		Annual Benefit Statement
<input type="checkbox"/> Self Employment		Profit/Loss Statement for the previous two months
<input type="checkbox"/> Unemployment Compensation		Award Letter or Weekly Pay Stub
<input type="checkbox"/> Social Security (Retirement, Disability or Survivor)		Annual Benefit Statement
<input type="checkbox"/> Pension		Annual Benefit Statement
<input type="checkbox"/> Long Term Disability Income		Annual Benefit Statement or Award Letter
<input type="checkbox"/> Rental Income		Rental Agreement with Expenses Itemized Or Annual Profit/Loss (Schedule E)
<input type="checkbox"/> Annuity		Documentation from your financial institution showing income received
<input type="checkbox"/> Individual Retirement Accounts (IRA) Income		Documentation from your financial institution showing income received
<input type="checkbox"/> Other		Signed and dated statement from person getting income. It must include gross income for last 2 calendar months and type of work performed.

No Income Declaration:

By checking this box, I declare my family 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.



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Agreement, Release of Information & Assignment of Benefits

Agreement: I am applying for services from the Early Intervention Program (EIP). By signing at the end of this section, I state that I have read this application and agree to the following:

I have a right to:

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

I have the responsibility to:

- Treat EIP, Evergreen Health Insurance Program (EHIP) and Ramsell Public Health Rx (Ramsell) with respect, consideration and honesty.
Give true, correct and complete information.

I understand that:

- I may have to pay a fee, called a cost share, to receive EIP services.
I must notify EIP of any changes that affect my eligibility. These changes include: Income, Address, Family Size and Health Insurance Coverage. I must send this notice within 20 days of the change. Failure to do so can lead to eligibility termination.
I understand that if I update my income with EIP, I may have to also update my income in the WA Healthplanfinder.
EIP will require me to use or apply for other programs for which I may be eligible before I receive EIP services.
EIP funding is limited. Services may change or end with short notice.
If I give false or incomplete information, EIP may deny or stop my eligibility. I may have to pay for services I received if I was not eligible for them.
EIP will use other state and federal data systems and other information to verify the information I give them.
I must respond to EIP requests for information. Failure to do so can lead to eligibility termination or denial.
If EIP is paying my insurance premiums through the Evergreen Health Insurance Program (EHIP), I understand that any premium reimbursement that is sent to me must be returned to EHIP.
If I want premium assistance through EHIP for a Qualified Health Plan in WA Healthplanfinder, I will need to select EHIP as my Sponsorship Representative. By selecting EHIP as my sponsor, I authorize EHIP to communicate and share information with the WA Healthplanfinder.
If I want premium assistance through EHIP for Qualified Health Plan (QHP), Healthcare for Workers with Disabilities (HWD), Medicare Part D (PDP) or Employer Sponsored Insurance (ESI) through my, my parent(s), my partner, my spouse employer, I give EIP & EHIP authorization to communicate and share information with them.
If EIP is paying my insurance premiums through EHIP, I must notify EHIP of any changes to my insurance coverage such as:
I am offered or get insurance from my job, Medicaid, Medicare, partner, spouse or other source.
I get a premium statement, premium coupon or coupon book.
I get a late premium notice, letter or phone call.
I get a premium change notice or letter.
If EIP is paying my insurance premiums through EHIP but I want to revoke this authorization and terminate the agreement, I must do so in writing to both EHIP and the health plan administrator.
If EIP is paying my insurance premiums through EHIP, I understand that my premium payment information will be released to EHIP, 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.

Release of Information: I give my permission for EIP to share information from this application and from subsequent documentation obtained by EIP with contracted providers, case managers, contracted vendors and 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)



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SECTION 2: HIV & HEALTH STATUS INFORMATION

EIP must confirm your HIV and health status in order to process your application. If you recently moved to Washington State would you like us to try and obtain this information from your previous state to verify HIV?

If so, please tell us the state from which you moved _____

Otherwise the bottom of this section must be completed by your health care provider.

Please indicate if you have tested positive for Hepatitis C? Yes [] No []

If so, would you like more information about medications that cure Hepatitis C? Yes [] No []

Please submit this form to us with this application or ask your health care provider to send it directly by mail or fax. You can call us at (877) 376-9316 if you have questions about this form.

Client Section - To Be Completed By The Client

Full Legal Name _____ Date of Birth _____ (mm/dd/yyyy)

Applicant or Legal Guardian Signature (Do Not Leave Blank)

Today's Date (mm/dd/yyyy) (Do Not Leave Blank)

I authorize my health care provider to release the information on this form to the Washington State Department of Health

Health Care Provider Section - To Be Completed By The Health Care Provider

Please answer the following questions about the patient:

HIV+ (lab confirmed) [] Yes [] No Date of Test: _____
Has ART been prescribed? [] Yes [] No If Yes, Date Prescribed: _____

Health Care Provider Signature - By signing below, you:

- Declare that you are the health care provider for the patient named above.
• Confirm that you have evidence of the patient's HIV status.
• Certify the information on this form is accurate and complete to the best of your knowledge.

Health Care Provider Signature (Do Not Leave Blank)

Today's Date (mm/dd/yyyy) (Do Not Leave Blank)

Health Care Provider - Please Print Name

Mail or Fax to:
EIP at PO Box 47841 Olympia, WA, 98501
Fax #: 360-664-2216



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SECTION 3: EHIP ENROLLMENT

EIP is contracted with an Insurance Benefit Manager, Evergreen Health Insurance Program (EHIP) to assist our clients with enrollment into insurance and paying premiums. Complete this form ONLY if you need assistance enrolling into insurance or want the Evergreen Health Insurance Program (EHIP) to pay your insurance premiums

Form with fields: First Name, Last Name, M.I., EIP ID, Date of Birth, HAS YOUR ADDRESS OR PHONE NUMBER CHANGED IN THE PAST SIX MONTHS?, New Address, New Phone, HAVE YOU USED TOBACCO PRODUCTS IN THE LAST 6 MONTHS?

Check here if you do not have insurance yet and need assistance with enrollment and payment. Please proceed to the required sections on the back.

If you are already enrolled in insurance, please provide the information below for the plan you want EHIP to pay for:

Form with fields: Insurance Company, Plan Name, What type of insurance plan is this?, 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, Annual Deductible, Next Premium Due Date, This Plan Has: Dental Benefits, Vision Benefits

Please complete the Required Authorization on the next page ->

Contact Information for EHIP
Main Line 206-323-2834 Toll Free 1-800-945-4256 ehip@ehip.org Fax: 206-323-0158



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Authorization to Obtain Insurance Information (REQUIRED)

Client Name: _____ Date of Birth: _____

Social Security or Subscriber ID number: _____

Name of Insurance Company / COBRA Administrator / Employer that Evergreen will be paying ("Insurer"):

Release of Information. I authorize the Insurer named above, and its health plan administrator(s), to discuss or release Personal Health Information (PHI) or Personal Financial Information (PFI) to the Evergreen Health Insurance Program ("EHIP") for the limited purpose of making or coordinating payment for my health plan benefits, and verifying eligibility for EHIP's services.

I also understand that PHI and PFI disclosed to EHIP may no longer be protected by federal privacy laws, and may be subject to re-disclosure by EHIP, subject to the conditions of any authorization I have given to EHIP.

Your rights with respect to this Authorization:

- You are not required to sign this authorization in order to receive health care benefits from the Insurer, but if you do not provide this authorization to EHIP, it may not be able to pay premiums on your behalf.
You may revoke this authorization at any time by notifying EHIP and the Insurer, but the revocation will not apply to actions that the Insurer has already taken based on your authorization.
You have the right to inspect and copy the protected health information covered by this authorization.
This authorization will remain in effect until 6 months after termination of benefits under the Insurer, unless earlier revoked.

Signature and Authorization. I, the undersigned, do hereby swear that I am the above-mentioned Client, or an authorized legal representative of the above-mentioned Client. I have read and understand the content of this Authorization Form. My signed authorization is voluntary and I acknowledge that the information released may include protected and individually identifiable information about me.

X
Signature of Client / Legal Representative

Today's Date (mm/dd/yyyy)

Printed Name of Legal Representative

Legal Representative's Relationship to Client

Authorization for Evergreen Health Insurance Program (EHIP) to Provide Services (REQUIRED)

While I am eligible and enrolled for premium assistance from EHIP, I agree to allow EHIP to make insurance premium payments to my insurance company / COBRA Administrator / Employer ("Insurer") on my behalf, and to provide any necessary updates to Insurer about my coverage or eligibility (for example, if I move, EHIP may notify the Insurer of my new address and request that the Insurer update their records).

I understand that if I lose my eligibility to receive services from EHIP (for example, because I no longer reside in Washington State), EHIP will notify the Insurer that EHIP will no longer be making premium payments on my behalf, and provide the reason for the discontinuation. I understand that the Insurer may discontinue my health insurance coverage when it receives this notice.

If EHIP has stopped making premium payments on my behalf because I lost eligibility, and I later become eligible again for premium assistance, I authorize EHIP to resume payment, and, if necessary, to request that the Insurer reinstate my health insurance coverage. I understand that reinstatement is subject to the Insurer's policies, and that it might be necessary for me to reapply to the insurer in order to resume coverage.

X
Signature of Client / Legal Representative

Today's Date (mm/dd/yyyy)

Printed Name of Legal Representative

Legal Representative's Relationship to Client

Checklist for Submitting a Complete EIP Application:

Proof of Legal Name

Please provide us a copy of one of the following to verify your full legal name:

- Any State driver's license or Identification card (can be expired)
- Passport

Proof of WA Residency

If you have a home address, please provide us a copy of one of the following to verify your WA Residency:

- Current Washington State driver's license or Identification card
- Washington voter registration card
- Utility bill (cell phone bills not accepted)
- Lease/rental/mortgage agreement

Income

If you and/or your family have income, please provide the required documentation listed on page 2 for all income types received by each person.

Insurance Card

If you have insurance, please provide us a copy of your insurance card.

Application completed in ink

Application filled out completely (Section 1 & Section 2*) with all required documentation, dates and signatures.

*Include Section 3 if applying for premium assistance too – however, please note application will not be deemed incomplete without Section 3.