



# Early Intervention Program Confidential Application

~Please tear off this sheet and keep it for reference~

The Early Intervention Program (EIP) helps eligible persons who live in Washington get health care for their HIV. EIP is a program of the Washington State Department of Health. EIP is not insurance. EIP is a program that helps pay for a variety of HIV related services including health insurance premiums.

- Prescription Drugs**  
 For uninsured clients, EIP pays for drugs on our formulary. For clients with insurance, we pay copays for drugs on our formulary. Clients may have to pay a cost share. Cost share amounts are less for insured clients.
- Medical Care**  
 For uninsured clients, EIP pays for limited HIV-related provider visits and tests. For clients with insurance, EIP pays for HIV-related costs during pre-exist periods and for deductibles up to \$1000. Some clients may have to pay a copay or co-insurance to their provider. Clients must go to providers and labs that contract with us.
- Dental Care**  
 EIP pays for limited dental care for clients who do not have other dental coverage such as dental insurance or Medicaid. Each eligible client is allowed up to \$2,500 per calendar year. Clients must go to providers that contract with us.
- Spenddown**  
 Beginning 4/1/09, EIP can no longer assist clients with meeting their Spenddown up front. Clients may use the payments we make for prescription drugs to help meet their spenddown.
- Insurance Premiums**  
 EIP helps eligible clients get health insurance and pays the premiums. We can also pay premiums for:
  - Medicare part D prescription drug plans (PDP)
  - Medicare Advantage plans with prescription drug coverage (MA-PD)
  - COBRA
  - Basic Health Plan (BHP)
  - Healthcare for Workers with Disabilities (HWD)
  - Employer-sponsored insurance
  - WSHIP

After clients enroll in EIP, they submit an application to the Evergreen Health Insurance Program (EHIP). Find the EHIP application at [www.ehip.org](http://www.ehip.org).

### How do you apply?

- Complete this application.
- Collect all required documents.
- Send the application and documents to EIP using one of the following:

<b>Regular Mail</b>	Early Intervention Program PO Box 47841 Olympia, WA 98504-7841	
<b>Fax</b>	360-664-2216  <b>Please Note:</b> If you send something by fax, use care and check the fax number. EIP is not responsible if you (or someone for you) send to a wrong number. We process applications in the order we receive them. We will not process a faxed application faster than a mailed one.	
<b>Overnight Mail</b> If you need us to process your application as soon as possible, send it by overnight mail using the following options:	<b>By Federal Express (FedEx) or United Postal Service (UPS):</b> Early Intervention Program 111 Israel Road SE TC2 – 2nd Floor Tumwater WA 98501	<b>By United States Postal Service (USPS):</b> Early Intervention Program PO Box 47841 Olympia, WA 98504-7841  **Be sure you send it EXPRESS MAIL OVERNIGHT. Any other form of mailing from USPS will be processed in order received.

### **A note about confidentiality**

We may talk with your case manager or health care provider or health insurance company about your eligibility. We can not talk to anyone else (family, friend) unless you fill out section 10 of the application.

### **How will we process your application?**

- If your application is **complete**, we will send you an eligibility letter. Your eligibility will begin on the first day of the month your application is postmarked. Usually we give eligibility for one year. If you are not eligible, we will tell you why.
- If your application is **not complete**, we will send you a letter telling you what we need. An incomplete application will delay your eligibility review.
- You may have to apply for Medicaid. If so, we will give you temporary eligibility and send you a Medicaid application.

### **How can you contact us?**

Please call us if you have any questions.

- 877-376-9316 toll-free outside of Thurston County
- 360-236-3426 in Thurston County.

### **What information can you find on our website?**

[http://www.doh.wa.gov/cfh/hiv\\_aids/client\\_svcs](http://www.doh.wa.gov/cfh/hiv_aids/client_svcs)

- This application
- EIP requirements
- Contracted medical/lab providers and services we cover
- Contracted dental providers and services we cover
- Contracted pharmacies
- Cost share schedule
- Formulary
- Staff directory

### **Helpful Definitions:**

**Early Intervention Program (EIP):** EIP administers Washington State's AIDS Drug Assistance Program (ADAP). It is funded by state and federal dollars to help eligible clients get much needed healthcare and insurance to improve their health. Our contact information is listed above.

**Evergreen Health Insurance Program (EHIP):** EIP contracts with an insurance benefit manager (IBM) to pay premiums for our clients and help them enroll in insurance such as WSHIP or COBRA. Our current IBM is Lifelong AIDS Alliance who administers the Evergreen Health Insurance Program (EHIP). EHIP may also be able to pay for approved individual or employer sponsored insurance plans. You can find out more information at [www.ehip.org](http://www.ehip.org) or by calling 800-945-4256.

**Washington State Health Insurance Pool (WSHIP):** WSHIP is Washington State's high risk insurance pool. HIV + clients may qualify for this insurance when no other insurance company will cover them. EIP can pay the premiums through EHIP. You can find out more information at [www.wship.org](http://www.wship.org) or by calling 800-877-5187.

**This EIP application is necessary if EIP will be paying for any of the services on the front side of this page. However, you may also have to complete an application with DSHS, EHIP, Social Security Administration and/or WSHIP.**

# Early Intervention Program Confidential Application



Early Intervention Program (EIP)  
 PO Box 47841  
 Olympia WA 98504-7841

For Official Use Only	
Date Mailed	Client ID#

You must use a pen and fill in as completely as possible.  
 Sections marked with an \* are required. Incomplete applications will delay eligibility.

<b>Section 1*</b> <b>Applicant</b>	Last name	First name		M.I.
	Current street address (Provide proof)	City	State <b>WA</b>	Zip code
	Mailing address (if different from above)	City	State <b>WA</b>	Zip code
	Date of birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Other		

**You must send proof of your current street address. We accept these items:**

- Valid Washington driver license or ID card (must be current)
- Washington voter registration card
- Utility bill (cell phones bills are not accepted)
- Lease/rental/mortgage agreement

<b>Section 2</b> <b>Demographic &amp; Other Information</b>	<b>We do not use this information to decide if you are eligible. We use it to improve our program and provide the right services for everyone. Thank you for your help.</b>		
	Please tell us your phone number: (     ) May we leave a message for you at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No		What is your Social Security Number?
	Are you Hispanic or Latino/a? <input type="checkbox"/> Yes <input type="checkbox"/> No		Check all of the following that apply to you. Are you: <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Other _____
	Would you like to receive documents from us in Spanish? ¿Quisiera usted recibir documentos de nosotros en español? <input type="checkbox"/> Yes (sí) <input type="checkbox"/> No		
	<b>If you have a case manager, please give us their information. If you would like a case manager, please contact us.</b>		
Case manager name	Agency	Phone number	

<b>Section 3*</b>	<b>HIV Documentation</b>	<b>REQUIRED FOR NEW APPLICANTS ONLY</b>	
		<b>If you are already an EIP client, please go to Section 4.</b>	
		<b>Applicant Authorization</b>	
		I authorize my case manager or health care provider to inform Washington State Department of Health about my HIV status. I understand that this documentation is required to apply for EIP.	
		_____ Signature of applicant	_____ Date
		<b>Case Manager or Health Care Provider Documentation</b>	
The applicant named above is applying for services from the Washington State Department of Health Early Intervention Program. Please provide the following information.			
<b>I HAVE EVIDENCE THAT THIS APPLICANT IS HIV+.</b>			
<input type="checkbox"/> I am the applicant's case manager <input type="checkbox"/> I am the applicant's health care provider			
_____ Signature of case manager or provider	_____ Date		
_____ Print name	_____ Phone number		
_____ Case manager or provider complete address			

<b>Section 4*</b>	<b>Family Size</b>	<b>We will decide your eligibility based on your income, resources and the people in your family who live with you.</b>			
		<b>Do you have a legally married spouse or registered domestic partner and/or dependant children who live with you under the age of 18?</b>			
		<input type="checkbox"/> Yes If yes, please fill in the table below with their information. You do not have to list your roommates.			
		<input type="checkbox"/> No – If no, proceed to section 5.			
				<b>Date of Birth (m/d/yy)</b>	<b>Does this person have income?</b>
		<b>Name (first &amp; last)</b>	<b>Relationship to you</b>		<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		

<b>Section 5*</b>	<b>Resources</b>	<b>Do you (and any family you listed in Section 4) have any of these resources?</b>		
		<b>Resource</b>	<b>Must select one</b>	<b>If yes, what is the value?</b>
		Cash, savings account, or checking account	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
		Real estate (not counting the home you live in)	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
		Trust fund	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
		Stocks & bonds	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Vehicles & recreational vehicles (not counting one vehicle for each licensed driver in section 4)	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		

<b>Section 6 *</b>	<b>Income</b>				
	<b>List below information about income for you (and any family you listed in Section 4) and provide documentation. If you (and your family) do not have income, please complete the "No Income Statement" below.</b>				
	<b>Income from working</b>				
	Who makes this income? _____	Gross income received per pay period (before taxes) \$ _____	How often are you paid? <input type="checkbox"/> weekly <input type="checkbox"/> every two weeks <input type="checkbox"/> monthly	<input type="checkbox"/> Check here if this is self-employment.	
	(Name)				
	Who makes this income? _____	Gross income received per pay period (before taxes) \$ _____	How often are you paid? <input type="checkbox"/> weekly <input type="checkbox"/> every two weeks <input type="checkbox"/> monthly	<input type="checkbox"/> Check here if this is self-employment.	
	(Name)				
	<b>Other income</b>				
	<b>Source</b>	<b>Who gets this income?</b>	<b>Gross monthly amount</b>	<b>Who gets this income?</b>	<b>Gross monthly amount</b>
	Unemployment benefits		\$ _____		\$ _____
Social Security		\$ _____		\$ _____	
Long term disability		\$ _____		\$ _____	
Other disability		\$ _____		\$ _____	
Retirement or pension		\$ _____		\$ _____	
Annuities		\$ _____		\$ _____	
Veterans benefits		\$ _____		\$ _____	
Child support		\$ _____		\$ _____	
Other		\$ _____		\$ _____	
<b>No income statement</b>					
If you (or you and your family) do not have any income, tell us how you support yourself. _____ _____					
I understand that if I give false information about not having any income, I may lose benefits and/or have to pay back for services I received.					
_____ Signature of applicant			_____ Date		

**Send us income documentation. We accept these items:**

- **Check stub** (must show name, pay periods and gross income received)
- **Unemployment stub**
- **Monthly benefit statement**
- **Annual benefit statement**
- **Child support order**
- **Bank statement showing direct deposit amounts** (to verify social security income or disability income ONLY)
- **Ledger – itemize the deductions**
- **Profit & loss statement**



Section 9 Health Care Providers	<b>Where do you get medical care?</b>	
	Provider Name: _____	Clinic Name: _____
	Address: _____ City: _____ Zip: _____	
	Provider Phone Number: (_____) _____	
<b>Where do you get dental care?</b>		
Provider Name: _____		
Clinic Name: _____		
Address: _____ City: _____ Zip: _____		
Provider Phone Number: (_____) _____		

Section 10 Release of Information	<b>If you want us to be able to talk to a friend or family member, list their names here.</b>		
	<i>**Case Managers: Please fill out Section 2**</i>		
	<b>Name (first &amp; last)</b>	<b>Phone number</b>	<b>Date of birth (for identity purposes)</b>

Section 11 * Applicant Agreement & Signature	<b>By signing below, you agree and understand that:</b>	
	<ul style="list-style-type: none"> <li>• I must respond to requests for information or action within deadlines or EIP may deny or stop my eligibility.</li> <li>• EIP may verify any information in this application.</li> <li>• I must report any change in my address, resources, income, or health care coverage. If EIP receives returned mail and cannot contact me, they may stop my eligibility.</li> <li>• I may have to pay a fee (cost share) to receive EIP services.</li> <li>• Funding for EIP is limited and services may be changed or eliminated as necessary.</li> <li>• EIP may require me to use or apply for other services before I receive EIP services.</li> <li>• EIP may limit services to those that are the most cost-effective for EIP based on my other coverage options.</li> <li>• EIP has grievance procedures that are available upon request. Making a grievance will not affect my EIP eligibility.</li> </ul>	
	<p>I give my permission for the Early Intervention Program, my health insurance companies and my health care providers, including my case manager and the Department of Social and Health Services, to share information about my medical care and insurance coverage. I give this permission for one year and 60 days from the date I sign this authorization.</p>	
	<p>I have read and understand the information in this application. The information on this form is true and complete to the best of my knowledge. I understand that if I give false or inaccurate information or fail to notify EIP of changes in a timely manner, I may lose benefits and/or EIP may require that I pay them back.</p>	
<p>_____</p> <p>Signature of applicant (<b>Do not leave blank</b>)</p>		
<p>_____</p> <p>Date (<b>Do not leave blank</b>)</p>		